

# **2006 AHRQ National PBRN Research Conference**

May 15-17, 2006

Bethesda Marriott  
Bethesda, Maryland

Accreditation Provided by  
Indiana University School of Medicine  
The University of Wisconsin Milwaukee College of Nursing,  
Continuing Education and Outreach Program

# 2006 AHRQ PBRN Research Conference

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May 15-17, 2006

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#### **Accreditation Statement** *(Physicians)*

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Indiana University School of Medicine and the U.S. Agency for Healthcare Research and Quality (AHRQ). The Indiana University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

#### **Credit**

The Indiana University School of Medicine designates this educational activity for a maximum of 14 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

#### **Note**

While it offers CME credits, this activity is not intended to provide extensive training or certification in the field.

#### **Disclosure**

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support, educational programs sponsored by Indiana University School of Medicine (IUSM) must demonstrate balance, independence, objectivity, and scientific rigor. All faculty, authors, editors, and planning committee members participating in an IUSM-sponsored activity are required to disclose any relevant financial interest or other relationship with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services that are discussed in an educational activity.

#### **Nursing Contact Hours**

The University of Wisconsin Milwaukee College of Nursing Continuing Education and Outreach Program will offer 17.1 contact hours for this program. University of Wisconsin-Milwaukee College of Nursing Continuing Education and Outreach Program is an approved provider of continuing education by the Wisconsin Nurses Association Continuing Education Approval Program Committee, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. A certificate will be awarded to participants at the completion of the conference.

## 2006 AHRQ PBRN Research Conference: The PBRN Resource Center

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Dear Colleagues:

Welcome to the second annual Primary Care Practice-Based Research Network (PBRN) Conference, sponsored by the Agency for Healthcare Research and Quality (AHRQ). This meeting is a part of AHRQ's on-going support of the growth and development of primary care PBRNs across the country. It offers you an opportunity to share your work and experiences in practice-based research while also learning from your colleagues in the field. Participants in this year's conference include directors and coordinators of PBRNs; network clinicians, researchers and staff; AHRQ's Federal and foundation partners; and others interested in learning more about research network efforts.

The goals of the Primary Care PBRN Research Conference are to:

- Disseminate findings and lessons learned through PBRN research
- Enhance the growth and development of primary care PBRNs through
  - Advancing the field of network research methodology
  - Sharing best practices for operating and managing PBRNs
  - Informing PBRNs about potential funding opportunities
- Promote communications/connections within the PBRN research community

We encourage you to take full advantage of the many opportunities this conference offers, including research presentations, participatory workshops, plenary sessions, poster presentations, and a "Funderson' Fair" featuring representatives from over a dozen NIH institutes and other organizations ready to tell you about potential sources of PBRN funding. At the same time, we recognize that some of the most valuable time you spend at the conference will be at receptions, lunches, and breaks where you can get to know PBRN researchers from across the country who share your interests.

On behalf of AHRQ, we welcome you to Washington D.C. and wish you a productive and enjoyable conference.

Sincerely,

Helen Burstin, MD, MPH, Director  
David Lanier, MD, Associate Director  
David Meyers, MD, Co-Director, Primary Care Research

Center for Primary Care, Prevention and Clinical Partnerships  
Agency for Healthcare Research and Quality

## 2006 AHRQ PBRN Research Conference: The PBRN Resource Center

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### The PBRN Resource Center [top](#)

The PBRN Resource Center (PBRN RC) provides resources and assistance to clinical and health services research taking place in Primary Care Practice Based Research Networks (PBRNs). This is accomplished through a network of primary care PBRNs registered with AHRQ. The PBRN RC provides support to registered PBRNs through a series of web-based seminars and the provision of technical research expertise to members. Registered PBRNs are also invited to participate in the Annual AHRQ PBRN Research Conference.

To support primary care PBRNs throughout the United States, AHRQ established the PBRN Resource Center in 2002. The PBRN RC was initially created to provide support solely to PBRNs funded through AHRQ's PBRN initiative. AHRQ recently expanded their mission so that the PBRN RC now serves all registered PBRNs.

Registration with the PBRN RC allows PBRN researchers and staff members access to:

1. Technical expertise for collecting and managing data
2. Methodological expertise and experience necessary for designing research projects
3. Resources for operating a primary care PBRN such as communication strategies, project and network management, and member recruitment and retention
4. Health Information Technology support and resources
5. Notification of funding and research opportunities
6. Forums for discussing PBRN issues with colleagues and experts in areas including quality improvement research within PBRNs

The PBRN Resource Center's role with regard to these activities includes:

1. Assisting AHRQ with its Annual PBRN Research Conference
2. Facilitating Peer Learning Group forums
3. Providing technical assistance with AHRQ's PBRN website as well assistance with other communication mechanisms available to registered PBRNs
4. Providing direct technical assistance to PBRNs in areas related to managing a network and conducting primary care research
5. Providing training in grant and peer-review journal writing
6. Maintaining a database of PBRN research conducted with the U.S.

The PBRN Resource Center is a collaborative effort between Indiana University and the National Opinion Research Center (NORC) at the University of Chicago.

For additional information, please contact Brenda L. Hudson at [brlhudso@iupui.edu](mailto:brlhudso@iupui.edu) or by phone at (317)630-8364.

## 2006 AHRQ PBRN Research Conference: Registering your PBRN

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### PBRN REGISTRY [top](#)

Recognizing the tremendous growth occurring around the country in Practice-Based Research Networks (PBRN), and their potential for the promotion of research and quality improvement in healthcare delivery, the Agency for Healthcare Research Quality (AHRQ) would like to invite all interested primary care networks to register with the PBRN Resource Center. **Registration is free!**

#### *Why Register?*

Registered PBRNs receive a number of benefits including: notification of AHRQ funding opportunities, the ability to participate in both general and topic-specific listservs and in the PBRN Resource Center sponsored web-based seminars (Peer Learning Groups). Additionally, members are invited to attend the annual AHRQ National PBRN Research Conference. Registration also offers your network access to technical assistance from AHRQ and the PBRN Resource Center on operational and research topics relevant to Primary Care PBRNs.

#### *Who can register?*

All PBRNs that contain more than fifty percent of primary care clinicians (e.g. pediatrics, family medicine, general internal medicine, and geriatrics) are eligible to register including already established PBRNs or those in the process of organizing. Furthermore, your network (or planned network) must consist of at least 15 clinicians or clinician practices.

#### *How to Register?*

Registration is easy. To receive a Username and Password for your network contact Brenda Hudson at [brlHUDSO@iupui.edu](mailto:brlHUDSO@iupui.edu) or visit our website at <http://secure.ahrq.gov/survey/pbrn/surveys>.

**The registry contains four sections, but only Section 1 must be completed to register a PBRN.**

THE 2006 AHRQ NATIONAL PBRN RESEARCH CONFERENCE, MAY 15 – 17, 2006

BETHESDA MARRIOTT, 5151 POKES HILL ROAD, BETHESDA MARYLAND

Monday, May 15, 2006

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CONFERENCE AGENDA

<b>REGISTRATION</b>				<b>12:00 P.M. – 4:45 P.M.</b> <b>Grand Salon A Foyer</b>
<b>PEER LEARNING GROUP WORKSHOPS*</b>				<b>1:00 P.M. – 4:45 P.M.</b>
<b><u>PBRN OPERATIONS:</u></b>		<b>Managing Multiple Projects: Mastering the Art of “Juggling” in 3 Easy Hours</b>		
<b><u>PBRN METHODS:</u></b>		<b>Expanding your Methods Skill Set</b>		
<b><u>QUALITY IMPROVEMENT IN PBRNs:</u></b>		<b>Moving Beyond Peer Review Publications - Disseminating your QI Research</b>		
<b><u>IT &amp; HIT IN PBRNs:</u></b>		<b>Health Informatics in the Research Setting</b>		
<i>*A description of the workshops and the presenters is available at the end of the agenda.</i>				
	<b>PBRN Operations</b> <i>(Congressional Salon 1)</i>	<b>PBRN Methods</b> <i>(Congressional Salon 2)</i>	<b>Quality Improvement</b> <i>(Congressional Salon 3)</i>	<b>IT/HIT in PBRNs</b> <i>(Pooks Hill/Kensington)</i>
<b>1:00 PM – 2:00 PM</b>	Understanding the Art of Project Management and its Methodology	Exploring the Fundamentals of Motivational Interviewing in Primary Care	Communicating with Policy Makers and Payers	What PBRNs Should Know about Health Informatics
<b>15 minute break (Congressional Foyer)</b>				
<b>2:15 PM – 3:15 PM</b>	Project Management: Assessing the Situation	Understanding Multilevel Modeling and Practice Based Research	Communicating with Policy Makers and Payers - Open Forum with the Panel	Strategies for Identifying Eligible Patients
<b>15 minute break (Congressional Foyer)</b>				
<b>3:30 PM – 4:30 PM</b>	Techniques and Organization Strategies Helpful in Managing Multiple Projects	Analyzing Data using Multilevel Modeling	Getting your Research in the Headlines	Practical Considerations for Applying Informatics Techniques in <i>your</i> PBRN
<b>15 minute Group Discussion to Develop Topics for Future Sessions</b>				
<b>COCKTAIL RECEPTION &amp; POSTERS</b>				<b>4:45 P.M.-6:00 P.M.</b> <b>Maryland Suite</b>
<b>EVENING PLENARY KICK-OFF</b> Carolyn Clancy, MD Director, AHRQ				<b>6:00 P.M – 6:15 P.M.</b> <b>Congressional Ballroom</b>
<b>PIONEERS OF PBRN EFFORTS IN THE U.S.</b> <ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Dr. David Lanier</li><li>▪ Eugene Farley, MD (ASPN)</li><li>▪ Robert Haggerty, MD (PROS)</li><li>▪ John Wasson, MD (Dartmouth CO-OP)</li></ul>				<b>6:15 P.M.-7:30 P.M.</b> <b>Congressional Ballroom</b>

<b>REGISTRATION</b>	<b>7:30 A.M.-11:30 A.M.</b> <i>Grand Salon A Foyer</i>
<b>OVERVIEW OF THE CONFERENCE</b> David Lanier, MD Associate Director CP3, AHRQ	<b>8:00 A.M.-8:15 A.M.</b> <i>Congressional Ballroom</i>
<b>PBRN RESOURCE CENTER UPDATE</b> William Tierney, MD & Dan Gaylin, MPA Co-directors, National PBRN Resource Center	<b>8:15 A.M.-9:00 A.M.</b> <i>Congressional Ballroom</i>
<b>PBRNS AT THE INTERFACE OF RESEARCH AND QUALITY IMPROVEMENT</b> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Dan Gaylin, MPA</li> <li>▪ James Mold, MD MPH (OKPRN)</li> <li>▪ Dale Bratzler, DO MPH (OK Foundation for Medical Quality)</li> </ul>	<b>9:00 A.M.-10:30 A.M.</b> <i>Congressional Ballroom</i>
<b>COFFEE &amp; POSTERS</b>	<b>10:30 A.M.-11:15 A.M.</b> <i>Maryland Suite</i>
<b>CONCURRENT SESSIONS I</b>	<b>11:15 A.M.-12:15 P.M.</b>
<b>IA – Follow-up with QI Panel</b> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Kevin Peterson, MD MPH</li> <li>▪ James Mold, MD MPH (OKPRN)</li> <li>▪ Dale Bratzler, DO MPH (OK Foundation for Medical Quality)</li> </ul>	<i>Congressional Salon 1</i>
<b>IB – Recruitment &amp; Retention of Clinicians and Practices in PBRNs</b> <ul style="list-style-type: none"> <li>▪ John Hickner, MD MSc (PBRN Resource Center)</li> </ul>	<i>Congressional Salon 2</i>
<b>IC – Nutrition and Obesity</b> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Laura Anderko, RN PhD</li> <li>▪ “Using Focus Groups to Identify Potential Culturally-Specific Interventions for Obesity Prevention in Young Children” - Barbara Sarter, PhD (LA Net)</li> <li>▪ “Poor Nutritional Habits: A Modifiable Predecessor of Chronic Disease” - Philip Sloane, MD MPH (NC-FP-RN)</li> <li>▪ <i>Research in Progress:</i> “Don’t Tell Me My Child is Overweight or Fat” - Cecelia Gaffney, MEd (CECH)</li> </ul>	<i>Congressional Salon 3</i>
<b>ID – Medication Safety</b> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Walter Calmbach, MD</li> <li>▪ “The Comparison of an Electronic Medical Record (EMR) and a Paper Medical Record (PMR) on Medication Counseling in Primary Care Clinics: A SPUR-Net Study” - Grace Kuo, PharmD (SPUR-Net)</li> <li>▪ <i>Research in Progress:</i> “In Partnership with the Community: Developing the Role of the Community Advisory Board (CAB) in the Implementation of a Rural Health Information Technology Project” - James Wallace (ORPRN)</li> <li>▪ <i>Research in Progress:</i> “Improving Geriatric Drug Safety in Underserved Practices” - Gurdev Singh, PhD (UNYNET)</li> </ul>	<i>Pooks Hill/Kensington</i>



<b>NETWORKING LUNCH</b>	<a href="#"><u>TOP</u></a>	<b>12:15 P.M.-1:15 P.M.</b> <i>Grand Ballroom A/B/C</i>
<b>PBRNs AND HEALTH DISPARITIES RESEARCH</b>		<b>1:15 P.M.-2:45 P.M.</b> <i>Grand Ballroom A/B/C</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Lisa Cooper, MD MPH (Johns Hopkins University)</li> <li>▪ George Rust, MD (Southeast Regional Clinicians’ Network)</li> <li>▪ Margaret Handley, PhD MPH (UCSF CRN)</li> <li>▪ Diane McKee, MD MS (NYCRRing)</li> </ul>		
<b>BREAK</b>		<b>2:45 P.M. – 3:00 P.M.</b> <i>Maryland Suite</i>
<b>CONCURRENT SESSIONS II</b>		<b>3:00 P.M.-4:00 P.M.</b>
<b>IIA – Follow-up with Health Disparities Panel</b>		<i>Congressional Salon 1</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Lisa Cooper, MD MPH</li> <li>▪ George Rust, MD (Southeast Regional Clinicians’ Network)</li> <li>▪ Margaret Handley, PhD MPH (UCSF CRN)</li> <li>▪ Diane McKee, MD MS (NYCRRing)</li> </ul>		
<b>IIB – Pediatric Research</b>		<i>Congressional Salon 2</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Mort Wasserman, MD MPH</li> <li>▪ “Validity of Parental Reporting of Recent Episodes of Acute Otitis Media” - Louis Vernacchio, MD MS (SCOR Network)</li> <li>▪ “Parental Gun Storage Patterns and Attitudes about Gun Safety Counseling and Gun Safety Education” - Jack Pascoe, MD (Dayton Primary Care PBRN)</li> <li>▪ <i>Research in Progress:</i> “Treating Sleep Terrors with Iron Fortified Multivitamins” - Christopher Bolling, MD (CPRG)</li> </ul>		
<b>IIC – Rural PBRNs</b>		<i>Congressional Salon 3</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Margaret Love, PhD</li> <li>▪ “Testing to Prevent Colon Cancer in Rural Colorado” - Linda Zittleman, MSPH (High Plains Research Network)</li> <li>▪ “Bridging The Gap Between Public And Private Health Care: Influenza-Like Illness Surveillance in a Practice-Based Research Network” – Zsolt Nagykaldi, PhD (OKPRN)</li> <li>▪ “2005 ORPRN Practice and Clinician Surveys” - Lyle Fagnan, MD (ORPRN)</li> </ul>		
<b>IID – Workshop: Technology and Practice Change to Support Patient-Centered, Collaborative Care</b>		<i>Pooks Hill/Kensington</i>
<ul style="list-style-type: none"> <li>▪ <u>Moderator</u> – John H. Wasson, MD</li> </ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li>1. Understand much more than the jargon of "patient-centered" and "collaborative care."</li> <li>2. Learn the practical implications of patient-centered, collaborative care for primary care practices.</li> <li>3. Be able to implement technologies and practice changes to support patient-centered, collaborative care.</li> </ol>		

<b>BREAK</b>	<a href="#"><u>TOP</u></a>	<b>4:00 P.M.-4:15 P.M.</b> <i>Maryland Suite</i>
<b>CONCURRENT SESSIONS III</b>		<b>4:15 P.M.-5:30 P.M.</b>
<b>IIIA – Workshop: Research Integrity Indicators for PBRNs</b>		<i>Congressional Salon 1</i>
<ul style="list-style-type: none"> <li>▪ <u>Moderator</u> – Victoria Neale, PhD (MetroNet)</li> </ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li>1. To consider the ethical challenges that confront PBRNs.</li> <li>2. To review the Institute of Medicine’s statements about deficiencies in the research integrity knowledge base.</li> <li>3. To discuss policies and procedures that promote PBRN research integrity.</li> <li>4. To develop strategies for PBRNs to monitor their research integrity.</li> </ol>		
<b>IIIB – Workshop: The Impact of Community Member Participation on PBRN Research</b>		<i>Congressional Salon 2</i>
<ul style="list-style-type: none"> <li>▪ <u>Moderator</u> – John Westfall, MD (High Plains Research Network)</li> </ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li>1. Illustrate examples of active community member involvement in the High Plains Research Network in Rural Colorado.</li> <li>2. Describe the impact of community involvement on PBRN research.</li> <li>3. Discuss strategies and needs for involving community members PBRN research.</li> </ol>		
<b>IIIC – PBRN Methods to Engage Clinicians</b>		<i>Congressional Salon 3</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Tom Stewart</li> <li>▪ “CD-ROM Decision Aid for Mammography Screening in Women 40-49” - William Curry, MD MS (Penn State Ambulatory Care Network)</li> <li>▪ “Screening Mammography for Older Women: PBRN Clinicians' Perceived Barriers and ‘Best Practices’” - Margaret Love, PhD (KAN)</li> <li>▪ “Optimizing the Limited Resources Available for Implementing Shared Decision-making in Primary Care” - France Legare, MD PhD (Laval University)</li> <li>▪ <i>Research in Progress:</i> “Integrating Practice-based Learning and Improvement Groups into a Practice-based Research Network” - Lucia Sommers, DrPH (UCSF Collaborative Practice Network)</li> </ul>		
<b>IIID – Refining Research in Progress: Providing Feedback to Your Colleagues</b>		<i>Pooks Hill/Kensington</i>
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Alan Adelman, MD MS</li> <li>▪ <i>Research in Progress:</i> “Effectiveness of a Diabetes Management Program in Primary Care Practice” - John Lynch, MPH (ProHealth Physicians)</li> <li>▪ <i>Research in Progress:</i> “Unanticipated Problems with Implementing Point-of-Care Lab Testing in Primary Care Settings” - Bennett Parnes, MD (CaReNet)</li> <li>▪ <i>Research in Progress:</i> “Feasibility of Incorporating PDA Use to Enhance the Self-Care Activities of Patients with Diabetes” - Samuel Forjuoh, MD (CenTexNet)</li> </ul>		

Wednesday, May 17, 2006

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## CONFERENCE AGENDA

<b><i>Breakfast and Poster Presentations</i></b>	<b>8:00 A.M.-9:00 A.M.</b> <i>Maryland Suite</i>
<b>CONCURRENT SESSIONS IV</b>	<b>9:00 A.M.-10:00 A.M.</b>
<b><i>IVA – Health Literacy</i></b>	<i>Congressional Salon 1</i>
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Carmela Lomonaco, PhD</li><li>▪ “Integrating Multiple Perspectives to Measure the Reach of Diabetes Self-Management Support Interventions in a Safety Net Primary Care Network” - Margaret Handley, PhD MPH (UCSF Collaborative Research Network)</li><li>▪ “Literacy in Primary Care: Comparison of Wisconsin to National Approaches and Attitudes” - Michael Grasmick, PhD (WREN)</li><li>▪ <i>Research in Progress:</i> “Evaluating the Effects of Cognitive Impairment and Low Health Literacy on Medication Adherence in Aging Minority Populations: A Significant Role for Primary Care Providers” - Charles P. Mouton, MD MS (DC PrimCaRe)</li></ul>	
<b><i>IVB – Colorectal Cancer</i></b>	<i>Congressional Salon 2</i>
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Kevin Peterson, MD MPH</li><li>▪ “Patient Reported Barriers to, and Facilitators of, Colorectal Cancer (CRC) Screening: Qualitative Study Results” - Kelly Devers, PhD (ACORN)</li><li>▪ “Improved Screening Colonoscopy Rates with Use of an Optimized Electronic Medical Record and Supportive Clinical Systems” - Jacob Prunuske, MD (Utah Health Research Network)</li><li>▪ “Colorectal Cancer Testing Among Patients Cared for by Iowa Family Physicians” - Barcey Levy, MD PhD (Iowa Research Network)</li></ul>	
<b><i>IVC – Chronic Care Model</i></b>	<i>Congressional Salon 3</i>
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – John Pascoe, MD</li><li>▪ “QuitLink: Partnering Clinical Practices and Telephone Quit Lines to Leverage an Improvement in the Quality of Tobacco Counseling in Primary Care” - Steven Rothenich, MD MS (ACORN)</li><li>▪ “A Controlled Trial of Methods for Managing Pain in Primary Care Patients With or Without Co-Occurring Psychosocial Problems” - Deborah Johnson (Dartmouth CO-OP)</li><li>▪ <i>Research in Progress:</i> “A Comprehensive Practice-Friendly Model for Promoting Healthy Behaviors. A Prescription for Health Study” - Alex Krist, MD (ACORN)</li></ul>	
<b><i>IVD – Workshop: Best Practices: Engaging Medical Students to Overcome Recruitment Challenges in Rural Networks</i></b>	<i>Pooks Hill/Kensington</i>
<ul style="list-style-type: none"><li>▪ <u>Moderator</u> – Aimee James, PhD MPH</li></ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"><li>1. Identify methods for involving medical students in PBRN activities.</li><li>2. Describe specific training and design concerns pertinent to engaging students in research.</li><li>3. Describe mutual benefits to students and practices resulting from participation in research.</li><li>4. State how this strategy can enhance relationships between practices and PIs.</li><li>5. Discuss innovative methods for relieving the research burden in practices.</li></ol>	

<b>BREAK</b>	<a href="#"><u>TOP</u></a>	<b>10:00 A.M.-10:15 A.M.</b> <i>Maryland Suite</i>
<b>OVERVIEW OF TODAY'S SESSIONS</b> David Meyers, MD CP3, AHRQ		<b>10:15 A.M.-10:30 A.M.</b> <i>Congressional Ballroom</i>
<b>PBRNS AND THE NIH ROADMAP INITIATIVE</b>  <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – David Meyers, MD</li> <li>▪ Barbara Alving, MD (Acting Director, NCRR-NIH)</li> <li>▪ Kevin Peterson, MD MPH (MN AFP Network)</li> <li>▪ John Hickner, MD MSc (PBRN Resource Center)</li> <li>▪ Robert Williams, MD MPH (RIOS Net)</li> </ul>		<b>10:30 A.M.-12:00 P.M.</b> <i>Congressional Ballroom</i>
<b>NETWORKING LUNCH</b>		<b>12:00 P.M.-1:15 P.M.</b> <i>Grand Ballroom A/B/C</i>
<b>FUNDERS' FAIR</b>		<b>1:15 P.M.-2:45 P.M.</b> <i>Grand Ballroom D/E</i>
<p>American Cancer Society</p> <p>National Cancer Institute (NCI)</p> <p>National Center for Complementary and Alternative Medicine (NCCAM)</p> <p>National Center on Minority Health &amp; Health Disparities (NCMHD)</p> <p>National Center for Research Resources (NCRR)</p> <p>National Committee for Quality Assurance (NCQA)</p> <p>National Heart, Lung and Blood Institute (NHLBI)</p> <p>National Institute on Aging (NIA)</p> <p>National Institute on Alcohol Abuse and Alcoholism (NIAAA)</p> <p>National Institute of Child Health &amp; Human Development (NICHD)</p> <p>National Institute of Diabetes &amp; Digestive &amp; Kidney Diseases (NIDDK)</p> <p>National Institute on Drug Abuse (NIDA)</p> <p>National Institute of Mental Health (NIMH)</p> <p>National Institute of Nursing Research (NINR)</p>		

**ADJOURN**

**2:45 P.M.**

**AHRQ's 2006 Annual PBRN Research Conference** [top](#)  
**Monday May 15<sup>th</sup> Workshop Descriptions**

The AHRQ 2006 Annual PBRN Research Conference will kick-off on May 15<sup>th</sup> at the Pooks Hill Marriott in Bethesda, MD at 1:00 PM with a series of workshops on PBRN Operations, PBRN Methodology and Research Design, Quality Improvement in PBRNs, and IT and HIT in PBRNs. Full descriptions of these sessions can be found below. Participants may choose to attend all three sessions offered under a single topic, or to attend sessions from multiple topics. A workshop schedule is provided below, after the session descriptions.

The workshops continue to develop themes and topics covered earlier in the year through the PBRN Resource Center's Peer Learning Groups. All meeting attendees are welcome and encouraged to participate in the Monday workshops regardless of prior involvement with a Peer Learning Group. At the end of the workshop sessions, participants will be asked to provide additional topics for the group to explore during the upcoming year. Participants will also have the opportunity to sign-up for participation in a Peer Learning Group.

**PBRN Operations: Managing Multiple Projects: Mastering the Art of “Juggling” in 3 Easy Hours**

**Presenter: Mary Ellen McCann**

**Part 1: Understanding the Art of Project Management and its Methodology**

In this session, Mary Ellen McCann will give an overview of how to manage a project successfully. Mary Ellen will discuss key components to project management as well as work with the group on successful strategies to overcome challenges to implementing project management strategies. Small groups will discuss the challenges to effectively managing one's workload.

**Part 2: Assessing the Situation**

In this session, Mary Ellen will discuss how do you evaluate and assess your current management system. We will examine the processes for this assessment including assessing each projects complexities, priorities, and objectives. The group will discuss causes for work overload, as well as the ramifications of delaying tasks.

**Part 3: Techniques and Organization Strategies Helpful in Managing Multiple Projects**

In this session, the group will discuss resources one can to use organize self (and network) for management of multiple projects. Learn new or improve upon skills to assist managers in planning, prioritizing, setting boundaries, and determining the appropriate level of detail to assist you in managing projects effectively.

## **PBRN Research Design and Methodology: Expanding your Methods Skill Set [top](#)**

**Presenters: Cecelia Gaffney, MEd and Miriam Dickinson, PhD**

### **Part 1: Exploring the Fundamentals of Motivational Interviewing in Primary Care – Cecelia Gaffney, MEd**

This session will provide a brief overview on adapting Motivational Interviewing (MI) techniques for use by primary care providers. Topics covered will include review of some key techniques, revising the patient visit to incorporate brief MI and basic instruction on conducting MI.

### **Part 2: Understanding Multilevel Modeling and Practice-Based Research - Miriam Dickinson, PhD**

The objective of this session is to provide a context and understanding of multilevel modeling and its appropriate applications in PBRN research. Topics covered will include terminology, and recognizing and accommodating a multilevel structure during the research design and sampling phase.

### **Part 3: Analyzing Data using Multilevel Modeling - Miriam Dickinson, PhD**

The second half of our series on multilevel modeling will provide an overview of the techniques used to analyze clustered data. Topics covered will include capabilities of statistical analysis packages, and the consequences of using traditional linear regression techniques to analyze clustered data.

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## **QI in PBRNs: Moving Beyond Peer Review Publications - Disseminating your QI Research**

**Presenters: Michael O’Grady, PhD, Jeff Lemieux, Janet Firshein, Linda Loranger**

### **Part 1: Communicating with Policy Makers and Payers - Michael O’Grady, PhD and Jeff Lemieux**

Session one, led by Michael O’Grady former Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services, and Jeff Lemieux, Director of AHIP’s new Center for Policy and Research, will provide a rare opportunity to hear from policy makers and payers about the information they need to make policy and coverage decisions related to quality improvement interventions and activities. The policy and payer panelists will each deliver a short presentation during this session.

### **Part 2: Communicating with Policy Makers and Payers - Open Forum with the Panel**

The first session will no doubt leave you with additional questions. “Does my research need to be complete before I can talk about it?” “If my intervention worked in Maine, will a payer in Missouri care about the results?” In this session, Dan Gaylin, Co-Director of the PBRN Resource Center, will moderate an open Q&A forum where you can get all your questions on translating research into policy answered.

### **Part 3: Getting your Research in the Headlines – Janet Firshein and Linda Loranger**

Janet and Linda, from Burness Communications, will lead an interactive workshop during this session. In the workshop, Janet and Linda will work with attendees to take a selection of PBRN QI research and transform it into a document ready for release to the media.

## **IT and HIT in PBRNs: Health Informatics in the Research Setting** [top](#)

**Presenters: Atif Zafar, MD and Abel Kho, MD,**

### **Part 1: What PBRNs Should Know about Health Informatics**

Atif and Abel will discuss how networks can use electronic means of data collection to help alleviate some of the problems associated with PBRN research (ex. duplicate data entry, syntactic errors, data validation and just-in-time data access). This tutorial will help you understand how informatics can be used within PBRNs to help solve some common problems.

### **Part 2: Strategies for Identifying Eligible Patients**

In this session, Atif and Abel will discuss in more detail the methods for implementing electronic systems for identifying patients. Many possible implementation strategies could be used, from a fully electronic system to hybrid paper-electronic processes. Some methods that will be discussed are “Backend” identification prior to patient arrival and “Just in Time” notification using computerized notifications.

### **Part 3: Practical Considerations for Applying Informatics Techniques in *your* PBRN**

In this session, Atif and Abel will address several problems in implementing IT in networks including topics such as how to pay for it, data modeling, data quality, and personnel and technical requirements. In this session, they will use case examples to illustrate how networks can successfully host an informatics endeavor in their PBRN.

#### **May 15, 2006 PBRN Annual Meeting Workshop Schedule:**

	<b>PBRN Operations</b>	<b>PBRN Methods</b>	<b>Quality Improvement</b>	<b>IT/HIT in PBRNs</b>
<b>1:00 PM – 2:00 PM</b>	Understanding the Art of Project Management and its Methodology	Exploring the Fundamentals of Motivational Interviewing in Primary Care	Communicating with Policy Makers and Payers	What PBRNs Should Know about Health Informatics
<b><i>15 minute break</i></b>				
<b>2:15 PM – 3:15 PM</b>	Project Management: Assessing the Situation	Understanding Multilevel Modeling and Practice-Based Research	Communicating with Policy Makers and Payers - Open Forum with the Panel	Strategies for Identifying Eligible Patients
<b><i>15 minute break</i></b>				
<b>3:30 PM – 4:30 PM</b>	Techniques and Organization Strategies Helpful in Managing Multiple Projects	Analyzing Data using Multilevel Modeling	Getting your Research in the Headlines	Practical Considerations for Applying Informatics Techniques in <i>your</i> PBRN
<b><i>15 minute Group Discussion to Develop Topics for Future Sessions</i></b>				

***Please join us at 4:45 PM for the cocktail reception and poster session, followed by the “Pioneers of PBRN Efforts in the U.S.” plenary session at 6:15 PM.***



## 2006 AHRQ PBRN Research Conference: Plenary Speaker Bios

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May 15-17, 2006

### **Barbara Alving, MD** [top](#)

Dr. Barbara M. Alving is the Acting Director of the National Center for Research Resources (NCRR) at the National Institutes of Health. Dr. Alving earned her medical degree—cum laude—from Georgetown University School of Medicine, where she also completed an internship in internal medicine. She received her residency training in internal medicine at the Johns Hopkins University Hospital, followed by a fellowship in hematology. Dr. Alving then became a research investigator in the Division of Blood and Blood Products at the Food and Drug Administration. In 1980, she joined the Department of Hematology at the Walter Reed Army Institute of Research and became Chief of the Department in 1992. She left the Army at the rank of Colonel in 1996 to become the Director of the Medical Oncology/Hematology section at Washington Hospital Center in Washington, D.C. In 1999, she joined the National Heart, Lung, and Blood Institute (NHLBI), serving as the Director of the extramural Division of Blood Diseases and Resources until becoming the Deputy Director of the Institute in September 2001. From September 2003 until February 1, 2005, she served as the Acting Director of NHLBI. In March 2005 she became the Acting Director of NCRR.

### **Dale W. Bratzler, DO MPH**

Dale Bratzler serves as the Principal Clinical Coordinator Oklahoma Foundation for Medical Quality, Inc. Bratzler has served as OFMQ's principal clinical coordinator since 1994 and both as a consultant and full-time employee. He also served as an associate professor of medicine and director of medical education for post-graduate training with the Oklahoma State University College of Osteopathic Medicine in Tulsa. Bratzler is also the principal clinical coordinator for the Pneumonia QIO Support Center. He is originally from Clinton, Mo. He earned a bachelor's degree from Central Missouri State University, his D.O. from the University of Health Science, College of Osteopathic Medicine and an M.P.H. from the University of Oklahoma Health Sciences Center College of Public Health. He also served on the OFMQ board for six years.

### **Miriam Dickinson, PhD**

Miriam Dickinson is an Associate Professor in the Department of Family Medicine and an Adjunct Associate Professor in the Department of Preventive Medicine and Biometrics, University of Colorado Health Sciences Center. She also serves as a Senior Scientist for the AAFP National Research Network. Miriam's areas of research and teaching interest include practice-based research, health services research, research methods, and multilevel modeling.

### **Eugene Farley, MD**

Eugene Farley serves as an emeritus faculty member in the UW-Madison Department of Family Medicine. He chaired the Family Medicine Departments at the University of Colorado and University of Wisconsin. Dr. Farley received a degree in Zoology and Political Science from Swarthmore College and a Medical Degree at the University of Rochester. He completed his internship at the Philadelphia General Hospital and his residency at the University of Colorado and Denver General Hospitals. He received his Medical Doctorate from Johns Hopkins University and developed and directed the Family Medicine Program at the University of Rochester. He was the field medical officer in charge at a clinic on the Navajo reservation where he studied TB and was a visiting professor in Social and Preventive Medicine at the University of West Indies.

**Janet Firshein** [top](#)

Janet Firshein is Vice President for Health Policy at Burness Communications. Janet has 20 years of experience writing about and analyzing health care policy issues. Janet joined Burness Communications in 1998 with extensive credentials as a highly respected health care journalist. During her tenure at Burness, Janet has directed and worked on projects related to health care policy, including access to care for the uninsured, public health and bioterrorism, quality improvement, breast cancer detection and diagnosis, and Medicare and Medicaid. Janet joined Burness after spending several years as an independent health care writer and reporter, working for National Public Radio, WNET television's special series on death and dying and drug and alcohol addiction, the British medical journal *The Lancet*, and *Reuters Health Daily*. In 1994, she was selected as a Kaiser Family Foundation Media Fellow in Health, where she spent a year studying the effects of managed care on medical education in the United States. She also is a recipient of the National Press Club Award for Outstanding Newsletter Journalism. Janet worked for five years as editor of the Washington-based newsletter *Medicine and Health*, and several more as its congressional correspondent. She also was editor for the newsletter *Health Legislation and Regulation*. Janet was the first Washington bureau chief of *Hospitals* magazine and spent nearly three years as a writer at the American Hospital Association. She earned her B.A. from the University of Maryland.

**Cecelia Gaffney, M.Ed**

Cecelia Gaffney is an Instructor in the Department of Community and Family Medicine at Dartmouth Medical School and a Senior Research Associate at the Norris Cotton Cancer Center. She is a recognized expert in translating smoking cessation research into clinical practice. In 1986, as Director of Health Promotion at a HMO in Texas, she pioneered providing smoking cessation as a covered member service. In 1992, while working with community health centers in New Hampshire, she designed and implemented the first program for Medicaid-reimbursed smoking cessation counseling for pregnant women. This reimbursement for evidence-based counseling remains in effect. While working in managed care, she developed one of the first outpatient diabetes education programs which, in its first year, of implementation reduced hospital claims costs 35%. Ms. Gaffney also assisted with developing cost-effective care alternatives for HMO members with AIDS. These alternatives reduced the average cost of providing care by 65%.

She has worked in practice-based research for over 15 years striving to translate behavioral science into relevant, doable prevention and treatment programs for primary care. She works with practices in the Dartmouth Coop and the Clinicians Enhancing Child Health (CECH) Network as well as primary care providers around the country. These programs range from breast and cervical cancer screening, depression screening, smoking cessation to multiple risk factor screening and health education for adolescents. She has extensive experience in health communications and has written patient education materials and public health reports read by thousands. She has authored papers in smoking cessation, practice-based prevention services and community health promotion. She also works with Dartmouth Medical School and other medical schools to develop and test training programs on behavioral counseling for undergraduate students and residents.

Ms. Gaffney is co-investigator on two current CECH projects focusing on improving behavioral counseling during well care visits. Funded by The Robert Wood Johnson Foundation, one uses PDAs to improve screening and to shift time normally spent gathering information to behavioral counseling. The second, funded by NICHD, again uses technology to screen for obesity risk factors for 4-10 years olds and prompt clinician counseling based on percent BMI and behaviors.

Ms. Gaffney serves as co-chair for the research workgroup of the National Partnership to Help Pregnant Smokers Quit and Chair of the Executive Board for the New Hampshire Smokefree Alliance. She worked as a medical technologist before returning to school and becoming a health educator. She received her Masters in Health Education (Phi Beta Kappa) from the University of Texas in 1985.

**Robert Haggerty, MD** [top](#)

Robert Haggerty, MD is a Professor and Chair Emeritus of General Pediatrics at University of Rochester Medical Center. Dr. Haggerty received his M.D. degree from Harvard Medical School. In 2004 he received the Alfred I. Dupont Award for Excellence in Children's Health Care. The author of more than 120 original papers, Dr. Haggerty is also editor or author of three books, one of which – "Ambulatory Pediatrics" – is in its fifth printing. In addition, he has authored nearly 200 book chapters, editorials, and abstracts. He has been visiting professor and/or lecturer at more than 50 institutions. Haggerty was a founding member of the Ambulatory Pediatric Association and one of its presidents.

**Margaret A. Handley, PhD MPH**

Margaret A. Handley, Ph.D., M.P.H., is an adjunct professor at the University of California (UCSF), San Francisco and co-director of the UCSF collaborative research network. Her areas of interest are: translational studies that link primary care epidemiology and public health; binational community health; and practice-based research on health disparities. Dr. Handley received her Ph.D. and M.P.H. in Epidemiology from the University of California, Berkeley.

**John Hickner, MD MSc**

John Hickner is a Professor of Family Medicine at The University of Chicago. He received his M.D. degree from Indiana University, completed his family practice training at the Medical University of South Carolina in Charleston in 1978, and earned a Masters degree in clinical research design and biostatistics at the University of Michigan School of Public Health in 1995. Dr. Hickner moved to The University of Chicago in September 2003 to be the Associate Chair for Research in the newly established Department of Family Medicine. From 1978 to 2000 Dr. Hickner practiced the full spectrum of rural family medicine, taught medical students and led a clinical research program called the Upper Peninsula Research Network at the Upper Peninsula Campus of Michigan State University. From 2000 to 2004 he was the founding director of the American Academy of Family Physicians (AAFP) National Research Network, and in 2001 he established the American Academy of Family Physicians Patient Safety Research Center. Patient safety, systems improvement, and quality in primary care practice are his research areas, supported by grant funding from the Agency for Healthcare Research and Policy. He is a founding member of the editorial board of The Journal of Patient Safety and on the steering committee of the Chicago Patient Safety Forum.

**Abel Kho, MD**

Abel Kho completed a B.S. degree in Theoretical and Applied Mechanics at the University of Illinois in Urbana-Champaign. He went on to attend medical school at the Medical College of Wisconsin. He completed a Residency in Internal Medicine at the University of Wisconsin, Madison, where he stayed on to serve a year as Chief Medical Resident. Dr. Kho joined the Regenstrief Institute in July 2003 after completing a chief residency in internal medicine. His work involves mining the Regenstrief Medical Record System (RMRS) to determine the utility of commonly ordered laboratory tests as predictors of mortality. Dr. Kho is also exploring novel methods to detect hospital disease outbreaks in realtime using existing laboratory and geographic data.

**Jeff Lemieux** [top](#)

Jeff Lemieux is the Senior Vice President directing AHIP's new Center for Policy and Research. Prior to joining AHIP, Lemieux was Executive Director of Centrists.Org, a small think tank dedicated to pursuing bipartisan policy solutions. Before founding Centrists.Org in 2003, Lemieux worked as a senior economist for the Progressive Policy Institute (PPI). At PPI, he was responsible for studies of overall economy including federal budget, tax, and entitlement issues, as well as health care. In 1998 and 1999, Lemieux served as the staff economist for the National Bipartisan Commission on the Future of Medicare, which was co-chaired by Senator John Breaux and Congressman Bill Thomas. Before joining the Commission, from 1992 to 1998, Lemieux was with the Congressional Budget Office, where he estimated the cost of national health reform plans and, later, the impact of Medicare reforms enacted in the Balanced Budget Act of 1997 and other laws. An economist specializing in health care and public finance, Jeff is the author of centrist proposals for health coverage, Medicare reform, and balanced budgets, and creator of long-term projections of entitlement spending and federal budgets used by Congress and the policymaking community. He has testified before the House Ways and Means Committee, the Senate Finance Committee, and other committees in Congress on Medicare reform, tax-based proposals to expand access to health coverage, chronic care management, and other topics.

**Linda Loranger**

Linda Lorange is Senior Vice President, and Director, Health Policy Team, Burness Communications. Linda has 20 years of experience in public relations and journalism, and is now a key strategist for health policy-related initiatives at Burness Communications. As the manager of the Health Policy team, Linda provides insight, strategic counsel, and effective media relations in a number of health policy areas, ranging from health care quality to health care financing, from access issues to health care for children. Linda is a highly effective media trainer and has trained numerous health policy researchers and leaders. Since joining Burness Communications in 1995, she has worked extensively with the Robert Wood Johnson Foundation, the Commonwealth Fund, the Harvard School of Public Health, the journal *Health Affairs*, and several health-related commissions. Linda began her career as a daily newspaper reporter in Connecticut, reporting for several years at the Hartford Courant. Prior to joining Burness, Linda headed communications for the Alpha Center, a Washington, D.C.-based health think tank, and at an RWJF-funded national program office focused on long-term care financing. She holds a B.A. in English and communications from the University of New Hampshire.

**Mary Ellen McCann**

Mary Ellen McCann is a consultant, facilitator and trainer, specializing in leadership development, strategic planning, communications, team building, customer service and priority management. Mary Ellen has a broad-based background with over 20 years of professional training and consulting experience in higher education, telecommunications and restaurant institutions. She is one of two full-time Organizational Development consultants for Indiana University and has served as a faculty advisor for a second-year graduate course in the Kelley School of Business, Indiana University. Mary Ellen's clients include: Ball State University; Vincennes University; Monroe County Public Library; and National Association of Auctioneers. Mary Ellen has presented at an international conference for the Association of Quality and Participation as well as provided training on leadership and strategic planning skills for the Council of Alumni Association Executives.

**Melissa Diane McKee, MD MS** [top](#)

Diane McKee is an Assistant Professor in the Department of Family and Social Medicine at the Albert Einstein College of Medicine. McKee joined the Department in 1992 after completing her residency at Brown University. McKee is the recipient of a Robert Wood Johnson General Physicians' Faculty Scholar Award. Currently, she is studying barriers that adolescent girls face in starting gynecologic care. McKee is also involved in a study assessing the clinical and economic impact of an intervention to increase breastfeeding in an urban primary care setting. Most recently she has taken on the role of directing the Department's Primary Based Research Network (NYCRING).

**James Mold, MD, MPH**

James Mold is a Professor and Director, Research Division, Department of Family and Preventive Medicine at Oklahoma University Health Sciences Center and the Director, Oklahoma Center for Family Medicine Research. Dr. Mold was the former Director of Oklahoma Physicians Research/Resource Center (OKPRN). OKPRN has expanded its research scope by focusing on translational research, successfully bridging the gap between research and quality improvement. Dr. Mold and his group have also pioneered a new research method called "best practices research" (PEAs) which involves identification of exemplars who provide characterization and dissemination of their methods. This method has been used to study some processes of care such as management of laboratory test results and management of prescription refills.

**Michael O'Grady, PhD**

Michael O'Grady is a Senior Fellow with NORC at the University of Chicago. Prior to joining NORC, Dr. O'Grady served as the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. The Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of Health and Human Services on policy development in health, disability, aging, human services, and science and data; and provides advice and analysis on economic policy. Prior to his appointment, Dr. O'Grady served as the Senior Health Economist on the majority staff of the Joint Economic Committee of the U.S. Congress. At the Committee, his work focused primarily on Medicare reform, the uninsured and other national health issues. Prior to joining the Joint Economic Committee, Dr. O'Grady was a Senior Research Director at Project Hope's Center for Health Affairs, where his work focused on Medicare reform issues. He holds a doctorate in Political Science from the University of Rochester.

**Kevin Peterson, MD MPH**

Kevin Peterson is an Assistant Professor in the Department of Family Practice and Community Health at the University of Minnesota Medical School, Minneapolis. Dr. Peterson chairs the National Diabetes Education Program's Health Care Provider Work Group, and is former Chair of the Federation of Practice-Based Research Networks. He serves on the Clinical Policies and Research Commission for the American Academy of Family Physicians, and directs EMDI, a quality improvement program for diabetes in St. Paul, MN. Dr. Peterson is principle investigator for the IMPACT trial (NIDDK, NIH) examining methods to improve diabetes care in primary care settings, and principle investigator for the University of Minnesota ACCORD project (NHLBI, NIDDK, NIH).



**George Rust, MD MPH** [top](#)

George Rust is a professor of family medicine and interim director of the National Center for Primary Care at Morehouse School of Medicine, previously serving as deputy director of the Center under former US Surgeon General, David Satcher, MD. He completed residency training at Cook County Hospital and is board certified in both family medicine and preventive medicine. In 1994, he was named Family Practice Educator of the Year by the Georgia Academy of Family Physicians. At the Morehouse School of Medicine he has also served as acting chair of the Department of Family Medicine and founding director of the Morehouse Faculty Development program. He is the author of numerous articles, book chapters, monographs, and peer-reviewed research publications related to primary care and underserved populations.

**John Wasson, MD**

John Wasson, MD, is The Herman O. West Professor of Geriatrics in Community and Family Medicine and Medicine at Dartmouth Medical School; Director of the Center for the Aging; and Research Director of the Dartmouth, Northern New England Primary Care (COOP) Research Network. He is also an advisor and faculty member for the Institute for Healthcare Improvement's Idealized Design of Clinical Office Practices, Pursuing Perfection, and IMPACT initiatives.

**Robert Williams, MD, MPH**

Robert Williams is Professor of Family and Community Medicine with the University of New Mexico. He graduated from Baylor College of Medicine, completed his Family Medicine Residency training at the University of Rochester, and received his MPH at Harvard. He is also the Director of Research Involving Outpatient Settings Network (RIOS Net), an innovative PBRN designed specifically to conduct research that has direct relevance to the Southwest's diverse and medically underserved populations. From an initial handful of members, RIOS Net has steadily grown to over 250 members who practice primary care in over 60 locations throughout New Mexico.

**Atif Zafar, MD**

Atif Zafar is a General Internist who trained in medical informatics at the Regenstrief Institute and Indiana University. His interests include the human-computer interface, data capture at the point-of-care, clinical decision support and order entry systems, systems engineering for healthcare and portable computing technologies. He developed a speech-recognition interface to the Regenstrief Medical Record System, has worked on designing a mobile computer EMR system, and is working on a distributed health information exchange system and on clinical education tools developed using web-technology. He serves on the staff of both the AHRQ PBRN Resource Center and the AHRQ National Resource Center for Health IT. Dr. Zafar received his medical degree from the University of Buffalo.

## 2006 AHRQ PBRN Research Conference: Concurrent Session Abstracts

May 15-17, 2006

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CONCURRENT SESSIONS I	11:15 A.M.-12:15 P.M.
<b>IC – <i>Nutrition and Obesity</i></b>	
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Laura Anderko, RN PhD</li><li>▪ “Using Focus Groups to Identify Potential Culturally-Specific Interventions for Obesity Prevention in Young Children” - Barbara Sarter, PhD (LA Net)</li><li>▪ “Poor Nutritional Habits: A Modifiable Predecessor of Chronic Disease” - Philip Sloane, MD MPH (NC-FP-RN)</li><li>▪ <i>Research in Progress</i>: “Don’t Tell Me My Child is Overweight or Fat” - Cecelia Gaffney, MEd (CECH)</li></ul>	

Title: [top](#)

Using Focus Groups to Identify Potential Culturally-Specific Interventions for Obesity Prevention in Young Children

Authors:

Sarter, Barbara, Ph.D.  
Jacques Barth, M.D.  
Theresa Woehrle, M.D.  
Lorena Luke, M.A.  
Carmela Lamonaco, Ph.D.  
Ronald Labugen, M.D.  
Lyndee Knox, Ph.D.

Context:

Childhood obesity is an increasing epidemic in the Hispanic population. Few studies exist on Hispanic parents' beliefs and actions about feeding their children and few culturally-specific interventions are described.

Objective:

To identify knowledge, attitudes, beliefs and behaviors held by immigrant Hispanic parents/caregivers concerning their children's health, weight, exercise pattern and nutrition. To identify possible interventions for lowering the rate of pediatric obesity that will meet the perceived needs of this group.

Design:

This was an exploratory/descriptive study using focus groups. The research team reviewed transcripts of the focus groups, identified recurrent themes until data saturation was obtained, and identified interventions for reducing child obesity that would be consistent with the needs and attitudes articulated by the study participants.

Setting:

Two family practice clinics located in inner-city Los Angeles served as the research setting. They are part of LANet, a Practice-Based Research Network (PBRN) in Los Angeles.

Participants:

A non-random sample of female and male parents/caregivers of Hispanic children ages 3-5 that are at-risk (65th or greater percentile) or currently overweight (85th or greater percentile) was recruited from two participating inner-city clinics in Los Angeles. A total of 38 women and 8 men participated in the study (38.9% had immigrated to the U.S. within the past 10 years).

Intervention or Essential Feature of Study:

A focus group guide was used that included questions on changes in eating habits and patterns since immigration, definitions of healthy eating for child, perceived barriers to implementing healthy eating practices, perceived influences on child feeding practices, and satisfaction with interactions with healthcare providers around the topic of child nutrition and feeding. Half way through the project, the guide was modified to include questions on themes that emerged during previous focus groups. A trained bilingual focus group facilitator conducted sessions. Sessions were audio taped and then transcribed and translated to English.

Outcome Measures:

Data were analyzed for content and themes using grounded theory methodology. Summary statements were developed based on this preliminary analysis on the attitudes, experiences and beliefs of caregivers about child health, eating and obesity. Finally, the research team identified potential areas of intervention that can be implemented by community-based primary care clinics to reduce the rate of obesity in young Latino children.

Results:

Participants reported significant changes in their eating practices and nutrition after arriving in the U.S.: consumption of greater quantities of meat and other proteins, increased consumption of processed foods, reduced consumption of fresh foods. Participants also reported significant disruption of family mealtimes after immigration. There were ambivalent beliefs and emotions concerning the significance of weight in children with larger body size. The influence of the father's eating practices on children's eating behaviors was felt to be particularly significant. Finally, participants indicated a desire for their providers to discuss more extensively with them issues of child nutrition and weight management. They also indicated inconsistencies in the nutrition information provided them by WIC, the schools, and their primary care providers.

Conclusions:

Potential interventions to prevent child obesity in Hispanic populations that emerged from this study include: suggesting a return to traditional foods with modifications to increase their nutritional value; helping the family develop and/or maintain a family mealtime routine even when there is a multi-family household in small quarters; identifying quick recipes utilizing fresh foods (vegetables, whole grains, beans, fruit) that can substitute processed foods; setting limits on portion sizes with children; increasing and coordinating information provided by primary care providers, schools and WIC on child nutrition with specific suggestions. More data is needed on the many barriers to maintaining a healthy food routine, such as the challenges of multi-family households.



Title: [top](#)

## Poor Nutritional Habits: A Modifiable Predecessor of Chronic Disease

### Authors:

Philip D. Sloane, MD, MPH

Nicole Gaskins

Alice Ammerman, PhD

C. Madeline Mitchell, MURP

### Context:

Many chronic illnesses, such as diabetes mellitus, osteoarthritis, and coronary artery disease, are related to poor diet and other modifiable lifestyle factors.

### Objective:

In a diverse, representative sample of adult patients from primary care settings, to examine associations between personal nutritional patterns and indicators of health, disease risk, and chronic illness.

### Design:

As part of a survey of adult patients conducted in the waiting rooms of four primary care practices, a health status was administered to 1785 study participants (recruitment rate: 75%).

### Setting:

Three private practices and one community health center serving a diverse population of rural and urban adults in North Carolina.

### Participants:

292 African Americans (17.3%), 1004 non-Hispanic whites (59.4%), 255 Hispanics/Latinos (15.1%), 126 American Indians (7.4%), with a mean age of 47.5 years.

### Intervention or Essential Feature of Study:

Cross-sectional, descriptive and correlative study.

### Outcome Measures:

A previously-validated, reliable 7-item nutrition questionnaire.

### Results:

Among study participants, 30% ate 3 or more fast food meals weekly, 29% drank 3 or more high-sugar beverages weekly, 22% ate 3 or more high-fat snacks weekly, 36% ate 3 or more desserts weekly, 11% reported eating "a lot" of margarine, butter, or meat fat; 62% ate 2 or fewer fruits or vegetables daily; and 42% consumed protein less than 3 times a week. Scores on a nutritional index were worse for prediabetics compared with diabetics, for young adults compared with older persons, and for persons reporting good or excellent health compared with those reporting fair or poor health. Other factors associated with poor nutritional habits included male gender, lack of physical activity, smoking status, alcohol consumption, and obesity.

### Conclusions:

Individuals at high risk for developing chronic illnesses later in life have poorer diets in comparison with people who are already ill. Promotion of better nutrition among younger adults without chronic illness has the potential for reducing risk and incidence of chronic disease and disability. Because of the high prevalence of chronic disease risk factors in that setting, the primary care office setting may constitute a particularly appropriate location for nutrition education.

Title: [top](#)

Don't Tell Me My Child is Overweight or Fat

Authors:

Cecelia A. Gaffney, MEd

Pamela W. Lee PhD

Ardis L. Olson, MD

Context:

BMI has become a common tool to identify children at risk for overweight or obese. Talking with parents of children with BMI greater than 85% presents a challenge for primary care providers. Parents are often overweight themselves and can be defensive about discussing these issues.

Objective:

What are the messages about exercise and nutrition to which parents of overweight children are receptive?

Design:

Parents of children with BMI >85%<95% and with BMI >95% were identified by pediatricians and invited to participate in a telephone interview. Twenty mothers completed a 30 minute interview using open-ended questions about current exercise and nutrition, advice they had received from their physician and their interest in discussing their child's exercise and nutrition with their clinician. Mothers were encouraged to talk about their challenges and barriers to helping their child maintain a healthy weight.

Current Challenges:

The topics of weight management, nutrition and exercise are so value laden that parents often feel guilty or defensive about discussing these issues if their child has an elevated BMI or they perceive that their child is being labeled as obese. Finding neutral or acceptable language to train providers to counsel parents of children during well visits is a first step to improving counseling and potentially changing child and parent behaviors.

Goals for Session/Questions for Audience Consideration:

We will present newly crafted messages based on our parent interviews and ask for feedback on how appropriate and useful practicing clinicians find them. We will be conducting training in the summer for clinicians in our current study and it would be extremely useful to "test" them with a diverse group of providers prior to taking them into the field.

CONCURRENT SESSIONS I	<a href="#">TOP</a>	11:15 A.M.-12:15 P.M.
<b>ID – Medication Safety</b>		
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Walter Calmbach, MD</li><li>▪ “The Comparison of an Electronic Medical Record (EMR) and a Paper Medical Record (PMR) on Medication Counseling in Primary Care Clinics: A SPUR-Net Study” - Grace Kuo, PharmD (SPUR-Net)</li><li>▪ <i>Research in Progress:</i> “In Partnership with the Community: Developing the Role of the Community Advisory Board (CAB) in the Implementation of a Rural Health Information Technology Project” - James Wallace (ORPRN)</li><li>▪ <i>Research in Progress:</i> “Improving Geriatric Drug Safety in Underserved Practices” - Gurdev Singh, PhD (UNYNET)</li></ul>		

Title: [top](#)

The Comparison of an Electronic Medical Record (EMR) and a Paper Medical Record (PMR) on Medication Counseling in Primary Care Clinics: A SPUR-Net Study

Authors:

Grace Kuo, PharmD MPH

Patricia D. Mullen, DrPH

Henry Hung-Wen Yeh

John Rogers, MD MPH MEd

Context:

Electronic medical records (EMR), when used by clinicians to prepare medication prescriptions, can prevent prescribing errors; however, little is known about whether EMR can increase medication counseling at the point of care.

Objective:

To compare the frequency of oral and written medication counseling by primary care physicians at paper medical record (PMR) clinics and EMR clinics.

Design:

A cross-sectional design; the study was conducted between January 2004 and March 2005. Record reviews and personal interviews were conducted after the index visit.

Setting:

The study was conducted in four representing SPUR-Net clinics in Houston, two using EMR and two using PMR.

Participants:

A convenience sample of 182 English-speaking adult patients from 22 physicians in two PMR primary care clinics and 250 patients from 25 physicians in two EMR clinics.

Intervention or Essential Feature of Study:

Outcome comparisons between EMR and PMR clinics were conducted.

Outcome Measures:

Frequency of patients reporting oral (indications and/or side-effects) or written counseling by their physicians.

Results:

A total of 432 patients (182 from PMR clinics and 250 from EMR clinics) completed the study; over two-thirds were female, in their early fifties, and taking an average of 7-8 medications. Patient race/ethnicity was similar at PMR and EMR clinics (59% non-Hispanic White, 13% Hispanic, 25% Black, and 2% Asian). Of the 1,095 medication entries, 665 (61%) medications had reported oral counseling for indications only, 228 (21%) had oral counseling for indications and side-effects, and 129 (12%) had written counseling plus oral counseling of indications, side-effects, and both indications and side-effects. The GLMM model showed that the frequency of oral counseling in the PMR (n=516) and EMR (n=579) clinics were 69% and 53% ( $t\text{-value}=2.49, p=0.0130$ ) for indications, and 22% and 20% ( $t\text{-value}=0.30, p=0.76$ ) for indications and side-effects; the frequency of written counseling in the two groups of clinics were 2% and 20% ( $t\text{-value}=-5.09, p<0.0001$ ).

Conclusions:

EMR was positively correlated with an increased frequency of written counseling and negatively correlated with oral counseling of medication indications.

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In Partnership with the Community: Developing the Role of the Community Advisory Board (CAB) in the Implementation of a Rural Health Information Technology Project

Authors:

James Wallace BA

Lyle J Fagnan MD

Paul Gorman MD

Anne King MBA

Context:

This research project (RxSafe) goal is to develop a web-enabled consolidated medication list (CML) to improve the quality and safety of healthcare for elders in rural assisted living (ALFs) and skilled nursing facilities (SNFs). Research on patient safety related to medications in rural communities is in its infancy, and little is known about rural ALF settings.

Objective:

Substantial input is obtained from members of the Community Advisory Board (CAB), which is established for the project. The CAB consists of community leaders with significant working knowledge of rural information technology implementation, and active expertise and participation in the county and community healthcare planning activities. A member of the CAB advises on the RxSafe Steering Committee. The Lincoln County Chronic Care Committee included a presentation of RxSafe as a part of an October 2005 conference on the Chronic Care Model.

Design

Approach:

1. Develop participatory research where patients, pharmacists, and clinicians participate in project design. Methods include: town hall meetings, key-informant interviews, and culture of safety surveys.
2. Flexible solutions - may achieve same goals by differing means. Sophisticated implementation and dissemination model, informed by research on practice change and guided by an understanding of diffusion of innovations.
3. Local reinvention - State of the art innovation from outside: local application, modification, implementation from within.

Current Challenges:

Challenges:

To align our research driven and funding agency-driven agendas with the needs and interests of the community; 2) Deliver real benefits to the community in a timely manner, to maintain and build the community relationship. 3) Characteristics of this CAB that may be hard to generalize in other locales.

Please describe the next steps you are planning for your study.

- 1-Stimulate inter-PBRN conversation on the role of community advisory boards within PBRN project specific research, and more generalizably within the context of national PBRNs.
- 2- Compare and contrast organizational objectives for Community Advisory Boards.
- 3- Review current literature for community advisory board roles.

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Improving Geriatric Drug Safety in Underserved Practices

Authors:

Gurdev Singh PhD

Ranjit Singh MD MBA

Context:

Adverse Drug Events (ADEs) are common and often preventable among older patients in ambulatory settings. Patients with cardiovascular disease appear to have the highest rates of ADEs. It is widely accepted that systemic problems, including the prevailing culture of blame are largely to blame. Crew Resource Management (CRM) approaches have been successful in aviation and other fields at helping organizations to move towards a culture of safety. This type of approach, suitably adapted, has the potential to offer benefits to primary care offices. The Institute of Medicine advocates the use of Failure Modes and Effects Analysis(FMEA) for identifying and solving systemic safety problems.

Objective:

To determine whether a novel approach, incorporating CRM principles, based on FMEA is effective for reducing ADEs among older adults and for creating a sustainable culture of safety in primary care settings.

Design:

15 practices in medically underserved communities within the Upstate New York Practice Based Research Network are randomized to one of the following groups: (1) Intervention facilitated by Practice Enhancement Associate (PEA), (2) Intervention without PEA, or (3) Control. The intervention involves a series of staff surveys including a safety attitudes questionnaire (SAQ), an FMEA survey, and team meetings to prioritize problems based on survey results, and to develop and implement solutions to prioritized problems. Outcomes measure: (a) changes in number and severity of ADEs based on chart review of a random sample of older adults with cardiovascular disease and (b) changes in safety climate, teamwork climate, and working conditions, before and after the intervention and in comparison with the control group.

Current Challenges:

Difficulty incorporating a complex intervention into busy practices. Limited time to discover sufficient numbers of ADEs. HIPAA issues.

Goals for Session/Questions for Audience Consideration:

To share our experience and invite guidance from participants.

CONCURRENT SESSIONS II <a href="#">TOP</a>	3:00 P.M.-4:00 P.M.
<p><b>IIB – Pediatric Research</b></p> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Mort Wasserman, MD MPH</li> <li>▪ “Validity of Parental Reporting of Recent Episodes of Acute Otitis Media” - Louis Vernacchio, MD MS (SCOR Network)</li> <li>▪ “Parental Gun Storage Patterns and Attitudes about Gun Safety Counseling and Gun Safety Education” - Jack Pascoe, MD (Dayton Primary Care PBRN)</li> <li>▪ <i>Research in Progress:</i> “Treating Sleep Terrors with Iron Fortified Multivitamins” - Christopher Bolling, MD (CPRG)</li> </ul>	

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Validity of Parental Reporting of Recent Episodes of Acute Otitis Media

Author:

Louis Vernacchio, MD, MSc

Richard M. Vezina, MPH

Allen A. Mitchell, MD

Context:

Validity of parental reporting of children's health outcomes is an important methodological issue in community-based pediatric research.

Objective:

To determine the validity of parental reporting of children's recent history of acute otitis media (AOM).

Design:

Parents of children participating in a pilot study of xylitol for the prevention of AOM were interviewed monthly for three months and asked whether their child had been diagnosed with AOM in the previous month. Medical records covering the time of study participation were reviewed for episodes of AOM.

Setting:

The Slone Center Office-based Research (SCOR) Network, a practice-based pediatric research network consisting of 498 pediatricians and family physicians from 42 states.

Participants:

Parents of children aged six months to three years participating in the xylitol pilot study.

Intervention or Essential Feature of Study:

Validation of parental reporting of recent AOM episodes by medical record review.

Outcome Measures:

Accuracy and predictive values of parental reports.

Results:

Medical records were obtained for 102 out of the 120 children in the study (85.0%). On a subject level, the reports of 95 parents (93.1%) agreed completely with the medical record. There were discrepancies for seven subjects (6.9%); six parents reported an episode of AOM that was not found in the medical record and one reported no AOM when two episodes were documented in the medical record. On an interview level, 264 of 272 interviews (97.1%) were in agreement with the medical record and eight (2.9%) were discrepant. The positive predictive value of a parental report of an AOM episode in the previous month was 85.0% (34/40); the negative predictive value of a parental report of no AOM episodes in the previous month was 99.1% (230/232).

Conclusions:

Parental reports of children's recent AOM episodes are generally accurate, especially negative reports. Parental errors are few and mainly involve overreporting of episodes.



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Parental Gun Storage Patterns and Attitudes about Gun Safety Counseling and Gun Safety Education

Authors:

John M. Pascoe, MD, MPH

Shalini G. Forbis, MD, MPH

Adrienne Stolfi, MSPH

Christopher A. Schlorman, BS

Terence R. McAllister, MD

Context:

There may be important differences in parental attitudes between civilian and military parents' attitudes and behaviors regarding firearms.

Objective:

To compare gun storage and safety attitudes and behaviors between military and civilian parents

Design:

Cross-sectional, two-page survey about parental firearms attitudes and behaviors

Setting:

Dayton Primary Care Practice-Based Research Network (PBRN) includes the primary care pediatric practice at Wright Patterson Air Force Base (N=574) and civilian pediatric practices in the Greater Dayton area (N=451)

Participants:

Convenience sample of parents whose children receive their primary health care from practices within the Dayton Primary Care PBRN

Intervention or Essential Feature of Study:

N/A

Outcome Measures:

N/A

Results:

Military parents (MP) were more educated, 85% > high school education (civilian parents [CP] 52% > HS education,  $p=0.00$ ). 18% of CPs and 27% of MP reported at least one gun in the home ( $p=0.00$ ). CPs were more likely to report that the child's doctor had talked about guns than MPs (11% v 6%,  $p=0.00$ ). CPs were also more likely to believe that physicians should ask about guns in the home (78% v 61%,  $p=0.00$ ), advise about gun storage (88% v 64%,  $p=0.00$ ) and advise about removal of guns from the home (48% v 24%,  $p=0.00$ ). MPs were more likely to report that the child had been taught gun safety by a parent (93% v 77%,  $p=0.00$ ). However, children of CPs were more likely to be taught gun safety through a formal course (17% v 7%,  $p=0.00$ ). All of the above differences remained significant and in the same direction when solely analyzing parents who had guns at home.

Conclusions:

Civilian parents are more likely to believe that physicians should ask about gun presence and advise about gun storage than military parents. Military parents are more likely to report that children have been taught gun safety by a parent.

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## Treating Sleep Terrors with Iron Fortified Multivitamins

### Authors:

Christopher Bolling, MD

Mark Deis, MD

Jeralyn Bernier, MD, MPH

Robert Siegel, MD

Jane Khoury, MS

### Context:

A frequently encountered sleep disorder in children from age two to ten is sleep terrors. This disorder presents a challenge to obtaining adequate rest for both parent and child, and has the potential to exacerbate behavioral conflicts, to harm self-esteem and to magnify other medical conditions due to sleep deprivation. Sleep terrors may be a manifestation of restless leg syndrome or other parasomnias. Some parasomnias are associated with subclinical iron deficiency. From the authors' clinical experience, it is hypothesized that therapy with standard multivitamins with iron will reduce sleep terrors.

### Objective:

- 1) To demonstrate that children with sleep terrors have depletion of iron stores before clinical anemia is present.
- 2) To demonstrate that sleep terrors can be reduced by addition of a regimen of iron-fortified multivitamins.

### Design:

The study population is CPRG practice patients aged two to ten years, not on iron therapy, who exhibit sleep terrors characterized by sudden waking due to terror combined with screaming, confusion, sweating and increased heart rate. Eligible children with at least three episodes in the last month will have a CBC and ferritin level obtained. Patients with anemia by CBC indices will be excluded. Those consenting will be randomized to receive standard multivitamins without added iron or the same preparation of multivitamin with iron. CBC, ferritin level and response to treatment, as determined by frequency of sleep terrors, will be measured after three months of therapy.

### Current Challenges:

- 1) Clarifying the role played by undiagnosed restless leg syndrome in children with sleep terrors
- 2) Funding
- 3) IRB approval
- 4) Informed consent issues

### Goals for Session/Questions for Audience Consideration:

This presentation will provide needed feedback on clinical relevance, logistic challenges, and study design. The audience will be asked to contribute expertise and advice regarding study methodology and application to practice.

CONCURRENT SESSIONS II	<a href="#">TOP</a>	3:00 P.M.-4:00 P.M.
<b>IIC – <i>Rural PBRNs</i></b>		
<ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Margaret Love, PhD</li> <li>▪ “Testing to Prevent Colon Cancer in Rural Colorado” - Linda Zittleman, MSPH (High Plains Research Network)</li> <li>▪ “Bridging The Gap Between Public And Private Health Care: Influenza-Like Illness Surveillance In A Practice-Based Research Network” – Zsolt Nagykaldi, PhD (OKPRN)</li> <li>▪ “2005 ORPRN Practice and Clinician Surveys” - Lyle Fagnan, MD (ORPRN)</li> </ul>		

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Testing to Prevent Colon Cancer in Rural Colorado

Authors:

Linda Zittleman, MSPH

Rodrigo Araya-Guerra, BA

John M. Westfall, MD, MPH

Context:

Despite effective early detection and prevention screening methods, colorectal cancer is the second leading cause of cancer death in the United States.

Objective:

As part of a CDC-funded study aiming to increase colorectal cancer screening (CRCS) rates in rural northeastern Colorado, this research activity assessed the reach and effect of an intervention in two communities in NE Colorado.

Design:

The intervention was piloted in two communities to assess residents' exposure to intervention materials. The research team conducted semi-structured interviews with a convenience sample of local community residents.

Setting:

Rural NE Colorado communities

Participants:

Local community residents over age 50 and clinic staff.

Intervention or Essential Feature of Study:

Using community-based participatory methods, the Joint Planning Committee (JPC), led the development of a multi-component, population-based CRCS intervention. Comprised of local rural community members, the JPC provided insight on rural cultures, access to local figures and organizations, and the ideas for intervention messages, materials, and dissemination strategies. The educational intervention heavily incorporates local residents and includes small and mass print media, community talks, and incentives.

Outcome Measures:

A quantitative outcome measure was the number of people who recalled or recognized each intervention component. Qualitative data included residents' reactions to each intervention component and feedback from clinic staff on the implementation of the intervention in the clinic setting.

Results:

Forty-six community members were interviewed. Over 85% recognized at least one intervention component, with reach varying by component. Exposure to intervention messages appeared to increase awareness of colon cancer and CRCS. The inclusion of local people was the most prominent and influential aspect of the intervention materials. Main messages remembered were "get tested" and "prevention". Several clinic staff and community members used the intervention as a vehicle to discuss colon cancer with others.

Conclusions:

Using a community participatory approach produced a message and dissemination model that was effective in reaching the target audience.

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Bridging The Gap Between Public And Private Health Care: Influenza-Like Illness Surveillance In A Practice-Based Research Network

Authors:

Zsolt, Nagykaldi, PhD  
James Mold, MD, MPH  
Dan Hollacher, BS  
Wendy Zhou, BS  
Mike Crutcher, MD, MPH

Context:

Practice-Based Research Networks (PBRNs) offer unique opportunities for bridging the gap between the public and private health care sectors. Traditional public health surveillance relies primarily on passive reports from hospitals, private health care providers and laboratories. By tapping into an electronic sentinel physician reporting system, the public health sector has the potential to increase the timeliness, sensitivity, and granularity of conventional disease surveillance while participating health care providers benefit from timely aggregated information about infectious diseases affecting their communities

Objective:

This presentation describes the development, testing and implementation of the OKAlert® - ILI System, a bidirectional, dual-use influenza-like illness (ILI) surveillance and messaging system during the influenza seasons of 2003-06 in the Oklahoma Physicians Resource/Research Network (OKPRN), a primary care PBRN.

Design:

We have analyzed the OKAlert® - ILI electronic database to determine the timeliness, completeness, validity, flexibility, and cost of the system based on sentinel ILI reports from 2003 to 2006. We interviewed OKPRN providers to receive personal feedback on the usefulness, acceptability, and simplicity of the system. We also compared ILI reports to influenza isolate laboratory data published by the OSDH to determine the specificity and sensitivity of electronic sentinel ILI reporting.

Setting:

OKPRN Network.

Participants:

OKPRN primary care clinicians.

Intervention or Essential Feature of Study:

Health IT implementation study.

Outcome Measures:

Evaluation parameters of the surveillance system according to CDC criteria.

Results:

Electronic sentinel ILI surveillance in a PBRN is feasible, effective, timely, and contributes significantly to existing disease surveillance systems. The OKAlert® - ILI system is easy to use, flexible, and it is well received by OKPRN providers. Regular feedback from the system provides very useful information for practicing clinicians to tailor patient care during the flu season.

Conclusions:

The success of the OKAlert® - ILI System demonstrates that PBRNs have a significant potential for bridging the communication gap between the public and private health care sectors. Their unique position empowers them to develop and implement disease surveillance solutions that are accepted and utilized.

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## 2005 ORPRN Practice and Clinician Surveys

### Authors:

Lyle J. Fagnan, MD  
Cynthia Morris, PhD, MPH  
Paul McGinnis, MPA  
Heather Angier, CCRP  
Anne King, MBA  
Nora Mattek, MPH

### Context:

A "snapshot" of the Oregon Rural Practice-based Research Network (ORPRN) including the influences of degrees of rurality

### Objective:

- 1) Describe the denominator for ORPRN studies and grant proposals
- 2) Compare ORPRN survey data with other primary care databases

### Design:

Cross-sectional.

### Setting:

129 ORPRN clinicians in 32 practices located in 26 rural Oregon communities

### Participants:

Practices and clinicians involved in ORPRN studies as of November 2005.

### Intervention or Essential Feature of Study:

Three-part survey-practice, clinician, and anonymous satisfaction

### Outcome Measures:

31/32 practices and 96/129 clinicians completed the practice and member surveys; 64 clinicians completed the anonymous satisfaction survey

### Results:

#### Practice survey

- 60% of the practices are private businesses
- 90 % of practices are accepting new patients, including Medicare and Medicaid patients
- 47% of practice payments come from Medicare and Medicaid
- 19/31 practices will have an Electronic Health Record (EHR) in place by December 2006

#### Clinician Survey

- Over 50% of clinicians make home visits and almost 2 out of 3 clinicians see patients in the nursing home
- 30% of ORPRN clinicians provide labor and delivery services
- Significant gaps exist regarding access to dental, mental health and substance services

#### Anonymous Survey

- Over 90% of clinicians report being very or somewhat satisfied
- The majority (80 to 90%) of clinicians feel in control of their income, hours, and clinical decisions
- 30% of clinicians report feeling isolated in their practice
- 1 out of 4 clinicians plan on leaving practice or retiring in the next 5 years

### Conclusions:

#### Implications for PBRNs:

The influence of the five working definitions of rurality on member practices and clinicians will be discussed. Each definition has strengths and weaknesses. The five definitions include: 1) The US Bureau of Census, 2) The Office of Management and Budget, 3) Goldsmith Modification, 4) Rural Urban Commuting Areas and 5) The Oregon Office of Rural Health

CONCURRENT SESSIONS II <a href="#">TOP</a>	3:00 P.M.-4:00 P.M.
<p><b><i>IID – Workshop: Technology and Practice Change to Support Patient-Centered, Collaborative Care</i></b></p> <ul style="list-style-type: none"> <li>▪ <u>Moderator</u> – John H. Wasson, MD (Dartmouth CO-OP)</li> </ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li>1. Understand much more than the jargon of "patient-centered" and "collaborative care."</li> <li>2. Learn the practical implications of patient-centered, collaborative care for primary care practices.</li> <li>3. Be able to implement technologies and practice changes to support patient-centered, collaborative care.</li> </ol>	

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Technology and Practice Change to Support Patient-Centered, Collaborative Care

Workshop Leader

John H. Wasson, MD

Please list additional workshop presenters and their network affiliation:

Deborah J. Johnson, BS

Dartmouth-Northern New England COOP Project

L. Gordon Moore, MD

IdealMicrosystem Practice Network

Please describe the intended audience for your workshop.

PBRN leadership and research investigators, network clinicians, coordinators, and staff

Please provide a synopsis of your workshop.

"Patient-centered, collaborative care" is health care jargon. But underlying the jargon is the principle that a patient who receives such care will strongly agree that "I receive exactly the health care I want and need exactly when and how I want and need it." Currently only about 1 in 4 Americans who have adequate financial resources can make that claim.

Think of a pyramid. At the apex is the highest level of "patient-centered, collaborative care." At the base are measures about "what's the matter" (from the clinical perspective) and "what matters" (from the patient perspective). As patients and clinicians act collaboratively on these measures, they climb closer to the apex of the pyramid.

Given the realities of health care in the United States, how can busy clinicians climb this pyramid?

In this interactive workshop attendees will learn about available technology and feasible practice changes that bridge the gap between desirable goals and limited time. Our past research and that of many others reinforce the observation that only technology (such as hardware and software) and the way humans use the technology (called *techne*) can not overcome the many obstacles for patient-centered, collaborative care. Despite these limitations, the examples will demonstrate ways that significant progress toward patient-centered, collaborative care can be made.

What are the learning objectives for your workshop.

1. Understand much more than the jargon of "patient-centered" and "collaborative care."
2. Learn the practical implications of patient-centered, collaborative care for primary care practices.
3. Be able to implement technologies and practice changes to support patient-centered, collaborative care.

Please provide an agenda for the 75 minute workshop.

Agenda:

1. Definitions and data supporting patient-centered, collaborative care. (10 minutes)
2. An illustration of resource planning for patient-centered, collaborative care. (10 minutes)
3. Discussion of barriers and opportunities for resource planning. (Group-15 minutes)
4. Description of technologies and *techne* (10 minutes)
5. Implementing technologies and *techne* in practice (10 minutes)
6. Discussion of implementation (Group -15 minutes)



CONCURRENT SESSIONS <i>III</i> <a href="#">top</a>	4:15 P.M.-5:30 P.M.
<p><b>IIIA – Workshop: Research Integrity Indicators for PBRNs</b></p> <ul style="list-style-type: none"> <li>▪ <u>Moderator</u> – Victoria Neale, PhD (MetroNet)</li> </ul> <p>Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li>5. To consider the ethical challenges that confront PBRNs.</li> <li>6. To review the Institute of Medicine’s statements about deficiencies in the research integrity knowledge base.</li> <li>7. To discuss policies and procedures that promote PBRN research integrity.</li> <li>8. To develop strategies for PBRNs to monitor their research integrity.</li> </ol>	

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Research Integrity Indicators for PBRNs

Workshop Leader

Victoria Neale, PhD

Please list additional workshop presenters and their network affiliation:

Kendra Schwartz, MD, MetroNet

Please describe the intended audience for your workshop.

PBRN Directors, Research Directors and Coordinators

If relevant, please describe any prerequisite knowledge required of your audience.

None

Please provide a synopsis of your workshop.

The practice-based research network (PBRN) movement has resulted in decentralized community-based research, which raises particular challenges to research integrity. While PBR offers the advantage of greater external validity, it also presents challenges that include: implementing standardized research protocols in decentralized settings; training and monitoring of responsible conduct of research practices among the community-based clinic staff; and data management and quality control issues. The purpose of this interactive workshop is to: 1) Identify PBRN research integrity challenges; 2) Discuss PBRN adherence to standards of research professionalism that relate to research integrity; and 3) Develop key indicators for PBRN research integrity.

What are the learning objectives for your workshop.

- 1) To consider the ethical challenges that confront PBRNs
- 2) To review the Institute of Medicine's statements about deficiencies in the research integrity knowledge base
- 3) To discuss policies and procedures that promote PBRN research integrity
- 4) To develop strategies for PBRNs to monitor their research integrity

Please provide an agenda for the 75 minute workshop.

The session will have three segments:

- 1) What is Research Integrity? An overview of the current concepts related to research integrity will be described, including factors that promote responsible conduct at the levels of the individual, the research group and the PBRN.
- 2) What Research Integrity Challenges Confront PBRNs? Following Institute of Medicine statements, challenges will be organized and discussed under 3 topic categories: a) Research Community (self regulation and quality assurance); b) Professional Development (training in responsible conduct of research, and research development for PBRN staff) and c) Research Process (study supervision, data management and publication policies).
- 3) What Are Indicators of PBRN Research Integrity? PBRNs will describe their policies and procedures that promote research integrity. Group discussion will identify key indicators of PBRN research integrity.

CONCURRENT SESSIONS <i>III</i> <a href="#">top</a>	4:15 P.M.-5:30 P.M.
<p data-bbox="282 275 997 350"><b><i>IIIB – Workshop: The Impact of Community Member Participation on PBRN Research</i></b></p> <ul style="list-style-type: none"><li data-bbox="323 380 1151 413">▪ <u>Moderator</u> – John Westfall, MD (High Plains Research Network)</li></ul> <p data-bbox="323 430 699 464">Workshop Learning Objectives:</p> <ol style="list-style-type: none"><li data-bbox="323 464 1430 527">4. Illustrate examples of active community member involvement in the High Plains Research Network in Rural Colorado.</li><li data-bbox="323 527 1162 560">5. Describe the impact of community involvement on PBRN research.</li><li data-bbox="323 560 1317 594">6. Discuss strategies and needs for involving community members PBRN research.</li></ol>	

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The Impact of Community Member Participation on PBRN Research

Workshop Leader

John Westfall, MD

Please list additional workshop presenters and their network affiliation:

Linda Zittleman, MPH - HPRN Research Coordinator

Rodrigo Araya-Guerra - HPRN PRA

Please describe the intended audience for your workshop.

PBRN leaders, staff, and medical providers. Community members interested in becoming involved in their local PBRN.

If relevant, please describe any prerequisite knowledge required of your audience.

None, just a desire to consider participatory research in your PBRN.

Please provide a synopsis of your workshop.

Community-Based Participatory Research (CBPR) has become an important and valuable method for conducting primary care clinical research. Funding agencies have recently started emphasizing the use of CBPR for research done within Practice-based Research Networks. The High Plains Research Network (HPRN) has been involving community members in research for 3 years.

This interactive session will provide a brief background on CBPR methodology and the history of the High Plains Research Network's Community Advisory Council (C.A.C.). Research staff and C.A.C. members will describe how community members are engaged in research and the impact of their participation on individual research projects. We will discuss the necessary components for developing and maintaining a Community Advisory Council and the challenges we have faced. We will conclude with an open discussion among workshop participants on how to support active participation by physicians and community members in a PBRN.

What are the learning objectives for your workshop.

The purpose of this workshop is to:

- 1) Illustrate examples of active community member involvement in the High Plains Research Network in Rural Colorado
- 2) Describe the impact of community involvement on PBRN research
- 3) Discuss strategies and needs for involving community members PBRN research

Please provide an agenda for the 75 minute workshop.

This interactive session will provide a brief background on CBPR methodology and the history of the High Plains Research Network's Community Advisory Council (C.A.C.). Research staff and C.A.C. members will describe how community members are engaged in research and the impact of their participation on individual research projects. We will discuss the necessary components for developing and maintaining a Community Advisory Council and the challenges we have faced. We will conclude with an open discussion among workshop participants on how to support active participation by physicians and community members in a PBRN.

This workshop will be led by a panel of HPRN research staff and C.A.C. members. The workshop will begin with a brief lecture format followed by ample interaction between attendees and the workshop panel. We will attempt to set up the environment for maximal audience participation.

CONCURRENT SESSIONS <i>III</i> <a href="#">top</a>	4:15 P.M.-5:30 P.M.
<p><b>IIIC – <i>PBRN Methods to Engage Clinicians</i></b></p> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Tom Stewart</li> <li>▪ “CD-ROM Decision Aid for Mammography Screening in Women 40-49” - William Curry, MD MS (Penn State Ambulatory Care Network)</li> <li>▪ “Screening Mammography for Older Women: PBRN Clinicians' Perceived Barriers and ‘Best Practices’” - Margaret Love, PhD (KAN)</li> <li>▪ “Optimizing the Limited Resources Available for Implementing Shared Decision-making in Primary Care” - France Legare, MD PhD (Laval University)</li> <li>▪ <i>Research in Progress</i>: “Integrating Practice-based Learning and Improvement Groups into a Practice-based Research Network” - Lucia Sommers, DrPH (UCSF Collaborative Practice Network)</li> </ul>	

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CD-ROM Decision Aid for Mammography Screening in Women 40-49

Authors:

William Curry, MD, MS

Alan Adelman, MD, MS

Marie Graybill, RN

Context:

When discussing screening mammography, both the patient and the provider need information about the benefits of the procedure and potential harms of screening such as false positive tests.

Objective:

To evaluate an interactive CD-ROM and a written decision aid to help women in their 40s make an informed decision regarding screening mammography.

Design:

Nonrandomized pilot test and comparison of a CD-ROM decision aid and paper decision aid.

Setting:

A university medical center campus and affiliated primary care clinics.

Participants:

Convenience sample of women age 40 - 49 years with no personal history of breast cancer, no history of mastectomy or breast biopsy and no family history (first degree relatives, i.e. mother or sibling) of breast cancer.

Intervention or Essential Feature of Study:

Comparison of the CD-ROM and paper decision aid.

Outcome Measures:

The primary outcome is change in the patients' knowledge and perception of risk.

Results:

Twenty one women read the paper decision aid, and 19 viewed the CD-ROM. The two groups differed only in higher self-assessment of health status in the paper DA group ( $p=0.034$ ) and younger age of first menstruation in the CD-ROM DA group ( $p=0.025$ ). In the CD-ROM DA group, the use of decision aids significantly improved knowledge that most abnormal mammograms in this age range are not cancer ( $p=0.044$ ). Both groups overestimated their personal breast cancer risk as well as the risk of a cohort of women similar to them. This was significantly reduced in the group who viewed the CD-ROM DA ( $p=0.023$ ). Confidence in making a mammography decision was improved in both groups (paper DA  $p=0.042$ , CD-ROM CA  $p<0.001$ ). Decisional conflict, although low in both groups, was reduced significantly in the CD-ROM DA ( $p=0.009$ ).

Conclusions:

Both the paper decision aid and interactive CD-ROM decision aid tested in this pilot study improved knowledge about breast cancer screening, reduced perception of breast cancer risk, and improved confidence in decision making. Only the CD-ROM decision aid showed significant improvements in risk perception as well as reduced decisional conflict about having a mammogram. Further testing of the CD-ROM DA is needed to define how this tool can best be implemented into daily practice in primary care.

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Screening Mammography for Older Women: PBRN Clinicians' Perceived Barriers and "Best Practices" (A Kentucky Ambulatory Network Study)

Authors:

Margaret Love, PhD

Steven Fleming, PhD

Suzanne Tyas, PhD

January Breeden, MPH

Kevin Pearce, MD, MPH

Context:

PBRN "best practices" research (J. Mold) creates a mechanism for identifying and disseminating successful strategies for improving practice among participating clinicians. Barriers to screening mammography among older women (>age 65) may be overcome by identification and sharing of these best practices.

Objective:

(1) Identify strategies to overcome perceived barriers to screening mammography in primary care practice

(2) Identify barriers for which practitioners do not seem to have successful strategies

Design:

Mail and Internet survey administered in February 2005, and telephone interviews in June and July.

Setting:

Kentucky Ambulatory Network (KAN) community-based primary care physicians, nurse practitioners, physician assistants, and certified nurse midwives.

Participants:

Seventy survey respondents (45% response rate of 156 deliverable surveys); 11 interviews.

Intervention or Essential Feature of Study:

Solicitation of effective processes to recommend or refer screening mammography.

Outcome Measures:

Percent of clinicians that identify a successful strategy and description of these best practices.

Results:

Clinicians identified systems-level, clinician-level, and patient-level challenges that they would want to collaborate with KAN to facilitate delivery of screening mammography to older women (e.g., identifying patients due for mammography, patients' anticipating discomfort from the mammogram). Twenty respondents (29%) indicated that they had a successful process to recommend or refer screening mammography. Most of these responses included specific system strategies to identify patients due for mammography. The opportunity to talk to patients about screening mammography was a key element in nearly all the strategies.

Conclusions:

Most of the successful strategies focused on creating the opportunity to bring up screening mammography with the patient. Such systems-level strategies may lend themselves to adoption by other clinicians. However, the content of clinician-patient discussions about screening mammography was not elucidated by this study, yet may be critical in addressing patient barriers to screening mammography.

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Optimizing the limited resources available for implementing shared decision making in primary care

Authors:

France Legare, MD, PhD

Michele Aubin, MD, MSc

Lucie Baillargeon, MD, MSc

Yvan Leduc, MD, PhD

Jean Maziade, MD, MSc

Context:

Shared decision making (SDM) aims at helping patients play an active role in decisions concerning their health. However, empirical data show that SDM has not been adopted yet by physicians.

Objective:

To report on the constraints encountered during an implementation trial of SDM in primary care and suggest strategies to improve future trials.

Design:

A before/after trial.

Setting:

Five family practice teaching units.

Participants:

120 family physicians (RR=75%) and their 923 patients.

Intervention or Essential Feature of Study:

The intervention comprised an interactive workshop, feedback and a reminder at the point of care.

Outcome Measures:

Constraints observed and recommendations for future implementation trials.

Results:

The first constraint that was addressed was the lack of a theory to implement change in clinical practice. We successfully used the theory of planned behaviour to identify which mechanisms were underpinning the intention of clinicians to implement SDM in their practice. A second constraint related to recruiting busy clinicians to commit to a longitudinal study. Therefore, the interactive workshop was also used to conduct a group discussion on barriers to implementing SDM in clinical practice. A third constraint concerned collecting data from both practitioners and patients after clinical encounters. To carry this out, 6 research assistants were hired to provide maximum coverage at the five clinical sites over a nine-month period. However, we estimated that only 2% of the clinical encounters that occurred during the study were entered in the data set.

Conclusions:

Throughout this trial, the use of theory provided insight into the underlying mechanisms by which change occurred in the intention of physicians to implement SDM in their practice. We also demonstrated that it was possible to use an interactive workshop for data collection as well as for implementing change. However, this study reminded us that new methods will need to be developed to maximise data collection from both practitioners and patients at the point of care.



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Integrating Practice-based Learning and Improvement Groups into a Practice-based Research Network

Authors:

Lucia S. Sommers, DrPH

Michael Potter, MD

Context:

The Collaborative Research Network (CRN) was established in 1984 by the Department of Family and Community Medicine, University of California, San Francisco (UCSF) to conduct practice-based research in primary care settings. The over 250 clinician members come from practice settings throughout Northern California and the Central Valley. The CRN has contributed to transforming primary care through a research agenda emphasizing innovations in health promotion, preventive health, and chronic illness care. Currently funded projects focus on cancer screening and diabetes self-management.

"Practice Inquiry" (PI) groups, affiliated with the continuing medical education programs of UCSF and Kaiser Permanente Medical Center in Oakland, California, have been meeting in San Francisco and the East Bay since 2002. Currently, eight clinician small groups meet regularly to explore the clinical uncertainty in individual, primary care patients through sharing clinical experience, expertise, and evidence and devising new approaches to cases while drawing implications for improving care clinic-wide.

To thrive, the CRN must build close relationships with practices interested in practice improvement and its transformative research agenda. To maximize the benefits of case-based learning from uncertainty, the PI groups need mentorship and technical/logistic support.

Objectives:

To determine:

- What would be the value of integrating PI groups into the CRN? Specifically, what could PI groups bring to CRN regarding new energy and ideas for learning from practice?
- How could CRN help PI groups develop better methods for case-based inquiry, searching for evidence-based sources, and surfacing knowledge/skills gaps?

Design:

A feasibility study will be conducted that will include:

- Focused discussions at PI group meetings and CRN quarterly meeting.
- An e-mail survey of PI and CRN members' viewpoints about the value of integration
- PI/ CRN - member sessions to review data from discussions/survey and draft plan for trial PI/CRN integration

Key Challenge:

To involve PI/CRN clinicians in Feasibility Study without expending more uncompensated time

Goals for Session:

- Feedback on integration concept
- Feedback on strategies to involve membership

CONCURRENT SESSIONS <i>III</i> <a href="#">top</a>	4:15 P.M.-5:30 P.M.
<p><b>IIID – Refining Research in Progress: Providing Feedback to Your Colleagues</b></p> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Alan Adelman, MD MS</li> <li>▪ <i>Research in Progress</i>: “Effectiveness of a Diabetes Management Program in Primary Care Practice” - John Lynch, MPH (ProHealth Physicians)</li> <li>▪ <i>Research in Progress</i>: “Unanticipated Problems with Implementing Point-of-Care Lab Testing in Primary Care Settings” - Bennett Parnes, MD (CaReNet)</li> <li>▪ <i>Research in Progress</i>: “Feasibility of Incorporating PDA Use to Enhance the Self-Care Activities of Patients with Diabetes” - Samuel Forjuoh, MD (CenTexNet)</li> </ul>	

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Effectiveness of a Diabetes Management Program in primary care practice

Authors:

John T Lynch MPH, Leah Alger MPH, Jonathan Rosen MD

Context:

In 2001, an evidence-based diabetes management program was introduced to 200+ primary care practitioners in 75 Connecticut practice sites. From 2001-2005, over 15,000 diabetic patients were identified and tracked. The program integrated scheduling, claims, and laboratory data into a diabetes patient registry, periodic feedback (patient listings and practitioner comparison reports), patient education via monthly mailings highlighting specific topics of diabetes care, diabetic practice templates, office recall of patients, and office visits for diabetes evaluation and management.

Objective:

The project objective is to evaluate the effectiveness of a Diabetes Disease Management Program via a *retrospective* analysis of the outcomes.

Design:

The primary HEDIS outcome goals reported on patient listings were:  $\geq 2$  diabetic encounters in 12 months; A1C level  $\leq 8$ ; and last lipid level  $\leq 100$ . For practitioner comparisons, these measures were converted to percentages of patients achieving the goals. Patients were stratified by level of risk.

Current Challenges:

On the surface, ALL pre/post outcome measures improved substantially. However, we are challenged by the definition of the study cohort, and the lack of a control population.

The length of 'intervention' varies. Practitioners joined and left the group practices throughout the 'study'. Patients were diagnosed and added to the intervention mix throughout the 'study'. Some patients died, others changed their insurance and no longer returned to the same practitioner, others were admitted to a SNF. The date of the last available lab result may be months prior to study closeout. Patients entered the study with varying degrees of illness severity. Some patients received additional 'interventions' in other settings (specialist, emergency department, hospital). Completeness of information about such outside interventions is lacking. 'Success' will be distorted by patient starting point, initial severity, length of time in the study, and uncontrollable outside interventions.

Goal for Session:

Understand methodological issues posed by retrospective population outcomes studies.

Questions for Audience Consideration:

How should we design a retrospective study of real world uncontrolled populations?

How should we define the population cohorts?

How should we define starting and endpoints?

How should we control for outside interventions?

How should we handle 'missing' data?

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## Unanticipated Problems with Implementing Point-of-Care Lab Testing in Primary Care Settings

Authors:

Bennett Parnes, MD

Javan Quintela

Linda Zittleman, MSPH

Wilson Pace, MD

Context:

Point-of-care lab testing in primary care is well-established, such as for urinalyses, pregnancy tests, etc. It has potential to improve efficiency by managing lab results with the patient present, increase patient safety by eliminating lost results, increase patient satisfaction, and improve outcomes.

Objective:

In a randomized-controlled trial in which point-of-care lipid testing is a component of the intervention, describe unanticipated barriers to the implementation of point-of-care technology.

Design:

The study is designed to improve cardiovascular risk in subjects with type 2 diabetes. The intervention consists of (1) Home blood pressure self-monitoring with a telephony or web-based reporting and feedback system, and (2) point-of-care lipid testing on all subjects who present to clinic visits fasting; results are obtained and available for clinician review during the clinical encounter. Ten clinics in SNOCAP are being randomized at the clinic level (about 30 consented subjects per clinic).

Current Challenges:

Multiple barriers to point-of-care lipid testing have been identified, with partial success thus far in overcoming them. These include:

1. The need for retraining of clinic staff in the technique due to staff turnover.
2. Concern by a hospital-owned clinic over loss of hospital lab business.
3. Extensive 3-month verification of the instrument, in spite of CLIA-waived status.
4. Requiring the study to pay for Medical Assistant time to perform test.
5. Requiring the on-site lab to perform the test instead of Medical Assistants, resulting in substantial delays.
6. Up to 12-month delay in approval of the instrument in a large health care system.

Goals for Session/Questions for Audience Consideration:

By getting audience feedback, new solutions to barriers may emerge. This may also be helpful for others planning point-of-care interventions. Finally, a modified version of this intervention on a larger scale has been funded, but not yet implemented. Audience feedback may help anticipate or resolve problems with this new project.

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Feasibility of Incorporating PDA Use to Enhance the Self-Care Activities of Patients with Diabetes

Authors:

Samuel Forjuoh, M.D., Dr.P.H.

Marcia Ory, Ph.D., M.P.H.

Michael Reis, M.D.

Glen Couchman, M.D.

Saundra Mason, BSN, RN

Sonia Holleman, BS

Context:

The feasibility of incorporating PDA use in the self-care activities of patients with diabetes is understudied.

Objective:

To document initial experiences in testing PDA use for diabetes self-care activity monitoring, highlighting research challenges.

Design

Adult patients with type 2 diabetes whose last measured HbA1c  $\geq 9.0\%$  (via medical records) and/or  $\geq 8.0\%$  (at research orientation visit) were recruited from 4 family practice clinics. A trained research assistant (RA) provided one-on-one training on the use of a loaned PDA with pre-installed diabetes management software. Participants were provided with a phone number to call for help and scheduled for return visits in 3 months. A monitoring phone call was made to each participant within 1 week of the orientation visit.

Current Challenges:

All participants accepted a PDA on loan and completed the initial training session lasting a mean of 54.7 minutes (SD=14.7; range 30-90). Four have dropped out. Our major challenge has been subject recruitment partly due to changes in HbA1c values over time. Of 626 patients invited for participation, only 67 (11%) have called an RA to schedule an orientation visit; 38 (57%) met all study inclusion criteria. Participants' mean age is 54.4 years (SD=9.9; range 35-77). The majority is female (66%) and white (61%); 63% have at least some college education and most reported an annual household income of \$30,000-\$49,999. A related challenge has been providing pledged incentives to potential subjects who fail to meet all study inclusion criteria at the orientation visit. Our third challenge relates to regulatory requirements regarding HbA1c testing. Participants' mean HbA1c is 10.1% (SD=1.6; range 8-14). The majority (95%) is computer literate; only 18% reported using a PDA before. Other challenges have included participants' loss of instructional folders, difficulty with data entry, and data loss due to incorrect saving of data after entry.

(FOR PRESENTATIONS) Goals for Session/Questions for Audience Consideration:

- 1) Highlight current challenges about incorporating health information technology into chronic disease management.
- 2) Obtain audience feedback about resolving current challenges.

CONCURRENT SESSIONS IV <a href="#">TOP</a>	9:00 A.M.-10:00 A.M.
<p><b>IVA – <i>Health Literacy</i></b></p> <ul style="list-style-type: none"> <li>▪ <u>Facilitator</u> – Carmela Lomonaco, PhD</li> <li>▪ “Integrating Multiple Perspectives to Measure the Reach of Diabetes Self-Management Support Interventions in a Safety Net Primary Care Network” - Margaret Handley, PhD MPH (UCSF Collaborative Research Network)</li> <li>▪ “Literacy in Primary Care: Comparison of Wisconsin to National Approaches and Attitudes” - Michael Grasmick, PhD (WREN)</li> <li>▪ <i>Research in Progress</i>: “Evaluating the Effects of Cognitive Impairment and Low Health Literacy on Medication Adherence in Aging Minority Populations: A Significant Role for Primary Care Providers” - Charles P. Mouton, MD MS (DC PrimCaRe)</li> </ul>	

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Integrating Multiple Perspectives to Measure the Reach of Diabetes Self-Management Support Interventions in a Safety Net Primary Care Network

Authors:

Margaret, Handley, PhD MPH  
Dean, Schillinger, MD;  
Hali, Hammer, MD;  
Jorge, Palacios, MA;  
Ivonne, McLean, BA;  
Audrey, Tang, NP;  
Franses, Wang, MA.

Context:

There is a growing recognition that assessing the reach of interventions is necessary, for implementation efforts in diverse populations and for determining if more vulnerable population are benefiting.

Objective:

To measure the reach of 2 diabetes self-management support interventions using perspectives from epidemiology, public health, and health promotion (participation, representativeness, and engagement).

Design:

Population-based registry criteria and provider authorization identified eligible patients who were recruited during clinic visits and randomized, with 9 months of intervention exposure or usual care follow-up.

Setting:

4 primary care clinics in the Community Health Network of San Francisco (CHN), part of the UCSF Collaborative Research Network.

Participants:

Diabetes patients with a recent HbA1c >8.0%, speak English, Spanish, or Cantonese, and have a primary care provider.

Intervention or Essential Feature of Study:

Automated telephone diabetes management (ATDM) uses language-specific interactive technology for weekly surveillance of self-care/symptoms; out-of-range responses trigger phone follow-up. Group medical visits (GMV) include monthly visits of 7-10 patients facilitated by a diabetes health educator and a clinician.

Outcome Measures:

Participation rates, patient representativeness, engagement.

Results:

4/9 clinics participated (44%), representing 1307 of 2262 eligible patients (58%). 197/1307 (15%) had provider exclusions, 109 (8%) reported ineligibilities, 78 (6%) refused, 584 (45%) were not approached, and 339 enrolled (26%). 115/117 (98%) providers determined patient eligibility; 103 (88%) had >1 patient enroll. Compared to eligible non-enrolled patients, enrolled patients were significantly more likely to speak Spanish (than English or Cantonese), and to be Hispanic or African American, but were similar regarding age, sex and recent HA1c. 112/133 (94%) ATDM patients completed 1+ calls; 49% of calls triggered call backs. 55/78 (71%) GMV patients attended 1+ times; 47 (60%) made 1+ behavior change action plan (preliminary analyses).

Conclusions:

Among safety net patients with diabetes, participation rates were fairly high among patients and

providers, enrolled and eligible patients differed by language and ethnicity, and intervention engagement was considerable.



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Literacy in Primary Care: Comparison of Wisconsin to National Approaches and Attitudes

Authors:

Michael Grasmick, Ph.D.

Jonathan Temte, M.D./Ph.D.

Amber Jaeger, MS

Van Yasek, Ph.D.

Context:

Low literacy is prevalent (40%) and affects patients' health status.

Objective:

To assess the attitudes and methods to improve communication with low literacy patients used by clinicians from WREN (n=90), a university department (UW-DFM: n=309) a state academy (WAFP: n=1358) and a random sample of the AAFP members not practicing in Wisconsin (AAFP: n=500).

Design:

A 12-question survey was sent by e-mail with a hyperlink for online data collection to all Wisconsin providers. This same survey was mailed to 250 AAFP physicians. 250 additional AAFP physicians received a postcard containing a URL for an online survey.

Setting:

U.S. Primary care offices.

Participants:

462 clinicians.

Intervention or Essential Feature of Study:

The survey URL was emailed to Wisconsin participants. Non-respondents received two reminder emails. Paper surveys or a postcards with a survey URL were mailed to AAFP participants. Non-respondents received two additional reminder letters or postcards spaced at three week intervals.

Outcome Measures:

Response rates across 5 groups and 3 methods of survey distribution. Prevalence of low literacy, impact on the quality of care and patient outcomes, frequency of screening, steps taken to improve communication, and impact of low literacy on patient's health status, quality of life and satisfaction.

Results:

Response rates were 60% (WREN), 19% (UW-DFM), 18% (WAFP), 38% (AAFP-mail) and 2.8% for (AAFP-postcard-URL). All groups significantly underestimated the prevalence of low literacy to a similar degree (17.4%), and had similar estimates of the impact of low literacy on health outcomes. Significant differences were found between Wisconsin Clinicians and non-Wisconsin Clinicians in the rates of screening for low literacy (7.1% vs. 17.5%).

Conclusions:

Clinicians recognize the importance of low literacy in the health of their patients, but underestimate its prevalence, and few employ screening. WREN accurately represents Wisconsin but has difference from a national sample.

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Evaluating the Effects of Cognitive Impairment and Low Health Literacy on Medication Adherence in Aging Minority Populations: A Significant Role for Primary Care Providers

Authors:

Charles P. Mouton, MD, MS

Finie Hunter, MPH

Context:

The medical literature contains several well-documented studies that estimate up to sixty percent of the minority population does not comply with the prescribed drug regimen. Although the reasons for lack of compliance may vary, the role of cognitive impairment has not been explored. Community-based primary care clinicians are the frontline and cornerstone for addressing the health care needs of poor and underserved populations.

Objective:

1) What is the prevalence of cognitive impairment as measured by the Clock Drawing Test (CLOX) among the target population consisting of urban, underserved patients seen in primary care practices, and to what extent do these two factors overlap in that population? 2) What are the effects of cognitive impairment on the ability of a patient to adhere to a prescribed drug regimen?

Design:

A multi-level study implemented at 25 member practices consisting of a cross-sectional demographic survey and two health assessments administered to a convenient sample for a two week period. Pilot study utilizes CLOX, an executive clock drawing test to screen for cognitive impairment and the Rapid Estimate of Adult Literacy in Medicine (REALM) test to measure health literacy. In addition, we will conduct stimulated patient chart reviews to record medication adherence behavior.

Current Challenges:

Current challenges include clinician and patient willingness to participate, recruiting practices outside of the Howard University Hospital Provider Network, insufficient manpower for providing assistance to short-staffed practices, and quality assurance of personnel administering study.

Goals for Session/Questions for Audience Consideration

- 1) How do cognition and executive decision making affect medication adherence?
- 2) What are the most reliable and practical methods of measuring medication adherence in this setting?
- 3) Does physician expectation play a role in reliability of data collected from patients?

CONCURRENT SESSIONS IV	<a href="#">TOP</a>	9:00 A.M.-10:00 A.M.
<b>IVB – Colorectal Cancer</b>		
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – Kevin Peterson, MD MPH</li><li>▪ “Patient Reported Barriers to, and Facilitators of, Colorectal Cancer (CRC) Screening: Qualitative Study Results” - Kelly Devers, PhD (ACORN)</li><li>▪ “Improved Screening Colonoscopy Rates with Use of an Optimized Electronic Medical Record and Supportive Clinical Systems” - Jacob Prunuske, MD (Utah Health Research Network)</li><li>▪ “Colorectal Cancer Testing Among Patients Cared for by Iowa Family Physicians” - Barcey Levy, MD PhD (Iowa Research Network)</li></ul>		

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Patient Reported Barriers to, and Facilitators of, Colorectal Cancer (CRC) Screening: Qualitative Study Results

Authors:

Kelly J. Devers, Ph.D.

Resa M. Jones, M.P.H., Ph.D.

Anton J. Kuzel, M.D.

Steven H. Woolf, M.D., M.P.H.

Context:

CRC is the second leading cause of cancer deaths in the United States. Understanding the factors that account for the low proportion of age-eligible adults that undergo CRC screening and possible ways to address them is essential for improving CRC screening rates and reducing mortality.

Objective:

To describe the factors that patients identify as their reason(s) for not undergoing CRC screening and patients' perspectives on potential solutions.

Design:

Literature review and analysis of open-ended survey item responses and focus groups.

Setting:

Diverse practices participating in the Virginia Ambulatory Care Outcomes Research Network (ACORN).

Participants:

Three-hundred seventeen (317) randomly selected patients ages 50 and older who answered an open-ended survey question about "the most important reason" why people might not undergo CRC screening, and 36 patients ages 45 and older who participated in six gender-specific focus groups about barriers to, and facilitators of, CRC screening.

Intervention or Essential Feature of the Study:

Identifying patient-reported barriers to CRC screening in general and to each of the four nationally recommended screening tests (i.e., fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and barium enema), and potential ways of overcoming these barriers.

Outcome Measures:

Patients' characterizations of: 1) barriers to CRC screening generally and to each of the four tests; and, 2) potential remedies.

Results: Although we identified many of the generic barriers (e.g., knowledge, attitudes and beliefs, time, costs) previously documented in the literature, we also identified specific barriers that have not been highlighted to date, and we gained additional perspectives from patients about potential solutions.

Conclusions:

While patients reported many barriers to CRC screening, they also identified numerous ways screening could be facilitated. These qualitative results will be used to develop a postal survey, which will allow us to gauge the relative importance of specific barriers, and help develop effective strategies to increase CRC screening rates.

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Improved screening colonoscopy rates with use of an optimized electronic medical record and supportive clinical systems

Authors:

Jacob, Prunuske, MD MSPH

Anna, Baker, MPH

Annie, Mervis, MSW

Linda, Johnson, RN

Steve, Donnelly, PhD

Julie, Day, MD

Mary, Parsons, MD

Michael, Magill, MD

Randall, Burt, MD

Context:

Colorectal cancer (CRC) is the third-leading cause of cancer death for men and women in the United States. Many eligible adults have not had CRC screening despite availability and reliability. Primary care physicians provide the majority of preventive health care services in the United States, and have an essential role in improving CRC screening rates.

Objective:

Can use of an optimized electronic medical record (EMR) reminder and supportive clinical systems increase the rate of CRC screening in a large primary care network?

Design:

Quasi-experimental prospective controlled trial

Setting:

University of Utah Community Clinics (UUCC), a 100,000 patient, seven-practice, multi-specialty, primary care network, linked by EMR, located in and around Salt Lake City, Utah.

Participants:

All patients age > 50 at UUCC, 50 physicians, 20 mid-level practitioners, and clinic support staff. Utah has a predominantly Caucasian population; however the study population includes a significant proportion of Hispanics, American Indians, and Pacific Islanders.

Intervention or Essential Feature of Study:

Optimized electronic reminder in EMR and associated supportive clinical systems, including practice redesign with expanded medical assistant role, and provider education.

Outcome Measures:

Monthly referral rates for colonoscopy in eligible patients and monthly proportion of visits at which patient is current for CRC screening.

Results:

The monthly colonoscopy referral rate for eligible patients at UUCC increased from 5.7% pre-intervention to 10.8% post-intervention with no overlap in control limits. This increase remains sustained after one year. The monthly proportion of visits where the patient is current for CRC screening increased from 36-40% pre-intervention to 42-45% post-intervention.

Conclusions:

Optimal use of an electronic reminder combined with associated supportive clinical systems and practice redesign provides sustained improvement in CRC screening rates in a large multi-specialty primary care network.



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## Colorectal Cancer Testing Among Patients Cared for by Iowa Family Physicians

### Authors:

Levy, Barcey, PhD, MD  
Dawson, Jeffrey  
Hartz, Arthur  
James, Paul

### Context:

With appropriate screening, colorectal cancer (CRC) can be largely prevented or effectively treated, yet about half of eligible Americans have not been screened.

### Objective:

The purpose of this study was to examine patient and physician factors associated with documented CRC testing according to national guidelines.

### Design:

Cross-sectional study of 511 randomly selected rural patients aged 55 to 80 years of 16 board-certified Iowa family physicians were enrolled in 2004. Patient survey and medical record information was linked with physician surveys. Predictors of CRC testing were examined using a regression procedure that accommodated random physician effects (2005-6).

### Setting:

The Iowa Research Network has 270 clinicians representing 150 practices. Our mission is to create new knowledge with relevance to rural primary care clinicians and their patients with the outcome of improving care for patients.

### Participants:

Physicians. In mid-November 2002, letters were mailed to 240 IRENE (Iowa Research Network) physicians briefly describing the proposed research and asking them to indicate whether they might be interested. A total of 57 physicians indicated their potential interest in the project and whether they or their partners performed FS or colonoscopy. Once funding for the project was received in 2003, 18 physicians were randomly selected from this group such that 6 each performed FS, colonoscopy, or neither procedure. 16 physicians eventually completed the study.

Patients. Participating physicians provided lists of their patients aged 55 to 80 years. Thirty male and 30 female patients were randomly chosen from this list and were mailed study materials. Medical records of consenting patients were reviewed.

### Intervention or Essential Feature of Study:

Information from patient self-report about attitudes and recollections concerning CRC screening was linked with information obtained from detailed, structured medical record review, and with information obtained from physicians by questionnaire. Reason for any CRC screening was recorded, so that diagnostic tests could be separated from screening tests.

### Outcome Measures:

The main outcome variable was whether a patient was "up to date" with colorectal cancer screening determined by medical record review. "Up to date" was defined as any of the following within the time interval noted from the initial mailing date: five take home hemoccult tests within the previous 5.5 years, flexible sigmoidoscopy within the previous 5.5 years, barium enema within the previous 5.5 years, or colonoscopy within the previous 10.5 years.

### Results:

Forty-six percent of patients were up to date with CRC testing in accordance with national guidelines. This percentage varied from 5% to 75% by physician ( $p < .0001$ ). Of the patients who were up to date, 89% had colonoscopy and 62% had symptoms prior to testing that could indicate CRC. The strongest univariate predictors other than symptoms were: patient recollection of physician recommendation (OR 6.4; 95% CI 4.2, 9.6) and physician documentation of recommendation (OR 14.1; CI 8.5, 23.3). A multivariable regression model showed testing in accordance with guidelines significantly increased with government insurance (OR 1.6; CI 1.2, 2.3), having a health maintenance visit in the preceding 26 months (OR 2.4; CI 1.4, 4.1), family history of CRC (OR 3.1; CI 1.6, 5.8), number of medical conditions (OR 1.2 for each additional condition; CI 1.1, 1.3), high importance of screening to patient (OR 2.6; CI 1.5, 4.5), patient satisfaction with doctor's discussions (OR 3.3; CI 2.2, 4.8), physician trained in flexible sigmoidoscopy (OR 2.3; CI 1.6, 3.4), and physician report of trying to follow American Cancer Society guidelines (OR 1.7; CI 1.2, 2.5). After excluding patients who had symptoms prior to screening, most of the odds ratios in the logistic regression analysis increased except that the number of medical conditions and physician trying to follow ACS guidelines became non-significant.

### Conclusions:

Less than half of rural patients received CRC testing, and most of those tested had symptoms. Physician recommendations and manner of presenting the recommendations greatly influenced whether patients were tested.

CONCURRENT SESSIONS IV <a href="#">top</a>	9:00 A.M.-10:00 A.M.
<b>IVC – <i>Chronic Care Model</i></b>	
<ul style="list-style-type: none"><li>▪ <u>Facilitator</u> – John Pascoe, MD</li><li>▪ “QuitLink: Partnering Clinical Practices and Telephone Quit Lines to Leverage an Improvement in the Quality of Tobacco Counseling in Primary Care” - Steven Rothemich, MD MS (ACORN)</li><li>▪ “A Controlled Trial of Methods for Managing Pain in Primary Care Patients With or Without Co-Occurring Psychosocial Problems” - Deborah Johnson (Dartmouth CO-OP)</li><li>▪ <i>Research in Progress</i>: “A Comprehensive Practice-Friendly Model for Promoting Healthy Behaviors. A Prescription for Health Study” - Alex Krist, MD (ACORN)</li></ul>	



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QuitLink: Partnering Clinical Practices and Telephone Quit Lines to Leverage an Improvement in the Quality of Tobacco Counseling in Primary Care

Authors:

Stephen Rothemich, MD, MS

Steven Woolf, MD, MPH

Robert Johnson, PhD

Sharon Flores, MS

Amy Burgett, RN

Pamela Villars, M.Ed., LPC

Vance Rabius, PhD

Context:

Counseling by clinicians promotes smoking cessation, but routinely providing more than brief advice is difficult in most U.S. primary care practices. Barriers include competing demands and inadequate office support systems.

Objective:

Telephone quit lines, whose staff deliver more effective intensive counseling, are proliferating in the U.S., but few work closely with clinicians to provide feedback or forward requests for cessation medications. Whether such a partnership improves outcomes has not been studied. We present an ongoing trial (ClinicalTrials.gov #NCT00112268) of such an intervention.

Design:

Cluster-randomized controlled trial. All practices implemented smoking status as a routine vital sign before a 3 month baseline, followed by allocation and analysis by practice. Outcomes are measured over 9 months.

Setting:

16 primary care practices in metropolitan Richmond, Virginia participating in the Virginia Ambulatory Care Outcomes Research Network (ACORN).

Participants:

789 adult smokers had participated in an exit survey by 4.5 months (study midpoint).

Intervention or Essential Feature of Study:

The intervention combines: (1) an expanded "vital sign" screening; (2) fax referral of smokers to the American Cancer Society quit line; and (3) quit line feedback to providers, including progress reports and prescription requests.

Outcome Measures:

The primary outcome is the frequency of intensive counseling (more than brief advice to quit), reported by patients in exit surveys. The study includes a qualitative component with interviews of patients and practice staff about the intervention.

Results:

Preliminary data at 4.5 months reveal intensive counseling in intervention practices increased from 30% to 43% (+13%) while in control practices it minimally changed from 34% to 33% (-1%).

Conclusions:

Exit surveys from this period suggest that the intervention is producing an increase in intensive counseling, although data collection must be completed to achieve adequate statistical power and assess sustainability. Details of the QuitLink system and the first 6 months of trial results will be presented.

Title: [top](#)

A Controlled Trial of Methods for Managing Pain in Primary Care Patients With or Without Co-Occurring Psychosocial Problems

Authors:

Deborah J. Johnson, BS  
Tim Ahles, PhD  
John H. Wasson, MD  
Janette Seville, PhD  
Bernard Cole, PhD  
Brett Hanscom, MS  
Therese Stukel, PhD  
Elizabeth McKinstry, MSN

Context:

Pain is a common reason for visits to primary care physicians (PCPs) that is often not well managed.

Objective:

To determine the effectiveness of pain management interventions suitable for PCPs.

Design:

Patients from rural practices reporting diverse pain problems with (N=644) or without (N=693) psychosocial problems randomized. Intervention received information tailored to problems and concerns (INFO). PCPs received feedback about patients' problems and concerns (FEED). Nurse Educator (NE) telephoned patients with pain and psychosocial problems to teach Problem-Solving strategies and basic pain management skills.

Setting:

Oldest research network in the country, reaching across northern New England (New Hampshire, Vermont and Maine).

Participants:

Patients reporting pain for at least a month's duration of 3 or above on 5-point scale stratified into two groups, patients without (Cohort 1) and with (Cohort 2) self-reported psychosocial problems.

Intervention or Essential Feature of Study:

Usual Care-received care as usual.

Patient Information and Physician Feedback (INFOFEED). "Prescription" letter generated tailored to patient's responses. Patient referred to self-care educational information. Physician sent computer-generated feedback form describing items endorsed by patient, particularly the presence and level of pain.

NE Intervention. Nurse-educators contacted patients by telephone. Conducted pain assessment and psychosocial problems; established patient preferences for types of pain management strategies; reviewed pain self-management strategies and provided supplemental materials; provided problem solving approach for psychosocial issues and; provided rapid feedback to physician regarding interventions initiated and identification of concerning symptoms or psychosocial problems.

Outcome Measures:

SF36, Functional Interference Estimate, and health care utilization.

Results:

Patients with pain and psychosocial problems, NE+INFOFEED significantly improved Bodily Pain ( $p = 0.02$ ), Physical Function ( $p = 0.02$ ), Emotional Function ( $p = 0.03$ ), and Vitality ( $p < 0.001$ ) at six months. Improvements maintained at 12 months. Compared to Usual Care, patients receiving INFOFEED experienced significant improvements at six months in social functioning and less interference in daily activities from pain.

Conclusions:

For patients with pain and psychosocial problems, telephone-based assistance with techniques such as problem solving, relaxation, sleep hygiene and activity pacing resulted in significant, sustained benefit.

Title: [top](#)

A Comprehensive Practice-Friendly Model for Promoting Healthy Behaviors. A Prescription for Health Study

Authors:

Alex Krist MD

Steven Woolf MD

Stephen Rothemich MD

Robert Johnson PhD

Diane B Wilson Ed.D

Kelly Devers PhD

Context:

Linking clinical and community resources can provide patients with necessary support to facilitate behavior change. Clinicians are well equipped to identify patients with unhealthy behaviors (A1), advise them to improve behaviors (A2), help reach agreement on whether to improve behaviors (A3), and follow-up on progress (A5). While clinicians frequently lack resources to provide intensive assistance (A4) in their office, community programs exist that can more effectively support patients' needs.

Objective:

To test a package of interventions designed to assist patients with healthy diet, increased exercise, smoking cessation, and alcohol moderation. An electronic health record (EHR) prompt system will facilitate the delivery of A1-3 and A5 in the office as well as refer patients to existing intensive community programs (A4). Interested patients will be able to select nine months of telephone counseling, group classes, online assistance, or usual care.

Design:

Nine practices using a common EHR within the Virginia Ambulatory Care Outcomes Research Network (ACORN) are participating. In a pre-post design, postal surveys will assess changes in health behavior among a random sample of patients from study practices. The EHR will track how clinicians use EHR prompts, allowing an assessment of how providers vary in their use of prompts and of the patients for whom prompts are used. A second survey, mailed to patients participating in intensive interventions, will measure patients' experience with the program and changes in health behaviors.

Current Challenges:

Creating an effective, user-friendly EHR prompt system is challenging. Prompts must be unobtrusive and appear at a time when clinicians can respond, integrating smoothly into the natural flow of clinical encounters. We will also discuss challenges in developing e-counseling and telephone counseling programs to which primary care patients can be referred.

Goals for Session/Questions for Audience Consideration:

It is anticipated that information from the presentation will assist the authors with:

1. Ensuring effective use of intensive counseling interventions;
2. Refining research questions about the intervention's Reach and Implementation; and
3. Analyzing preliminary experience about barriers to creating EHR prompts.

CONCURRENT SESSIONS IV <a href="#">top</a>	9:00 A.M.-10:00 A.M.
<p data-bbox="331 279 1024 384"><b>IVD – Workshop: <i>Best Practices: Engaging medical students to overcome recruitment challenges in rural networks</i></b></p> <ul style="list-style-type: none"> <li data-bbox="370 401 906 436">▪ <u>Moderator</u> – Aimee James, PhD MPH</li> </ul> <p data-bbox="370 474 745 506">Workshop Learning Objectives:</p> <ol style="list-style-type: none"> <li data-bbox="380 510 1224 541">6. Identify methods for involving medical students in PBRN activities.</li> <li data-bbox="380 543 1360 604">7. Describe specific training and design concerns pertinent to engaging students in research.</li> <li data-bbox="380 606 1373 667">8. Describe mutual benefits to students and practices resulting from participation in research.</li> <li data-bbox="380 669 1317 701">9. State how this strategy can enhance relationships between practices and PIs.</li> <li data-bbox="380 703 1292 735">10. Discuss innovative methods for relieving the research burden in practices.</li> </ol>	

Workshop Title [top](#)

Best Practices: Engaging medical students to overcome recruitment challenges in rural networks

Workshop Leader

Aimee, James, PhD, MPH

Please list additional workshop presenters and their network affiliation:

KA Greiner, MD, MPH, Network Director;

KK Engelman, PhD, Affiliated Researcher;

L Mussulman, MA, Project Director;

E Ellerbeck, MD, MPH, Affiliated Researcher

Please describe the intended audience for your workshop.

PBRN directors, investigators, and practitioners

Please provide a synopsis of your workshop.

The distance between practices is one challenge for rural PBRNs. The KPEPR network spans over 400 miles across rural Kansas. Budget limitations have constrained our ability to hire research coordinators at every practice.

To address this challenge, we developed sustainable research training and placement programs for medical students completing elective and required rural preceptorship rotations. Students blend research activities and clinical activities under the supervision of their precepting network physicians. Students perform project activities including recruitment, eligibility screening, and data collection.

Several studies in the KPEPR network either have been completed or are underway that successfully use this strategy. For example, in the NIH-funded Kan-Quit smoking cessation study, students in 52 practices screened over 1800 patients, recruiting 750 smokers into a 24-month randomized trial. The same approach will be used for a colorectal cancer screening intervention starting in June 2006.

Engaging medical students in PBRN functions not only facilitates project recruitment and implementation, but also exposes students to primary care research. Students can relieve practice research burdens and maintain program visibility within a network. Student involvement and enthusiasm for research within practices strengthens academic and practitioner ties.

What are the learning objectives for your workshop.

Upon completion, participants will be able to:

- (1) Identify methods for involving medical students in PBRN activities;
- (2) Describe specific training and design concerns pertinent to engaging students in research;
- (3) Describe mutual benefits to students and practices resulting from participation in research. State how this strategy can enhance relationships between practices and PIs;
- (4) Discuss innovative methods for relieving the research burden in practices

Please provide an agenda for the 75 minute workshop.

- (1) KPEPR and rural preceptorship programs;
- (2) Use and limitations of medical students: research education, engaging students in rural network research, and integrating medical education and PBRN activities to strengthen relationships and improve research outcomes;
- (3) Student training and involvement in PBRN research: Examples from KPEPR research activities.

## 2006 AHRQ PBRN Research Conference: Poster Presentations & Abstracts

May 15-17, 2006

### POSTERS [top](#)

Poster #	Last Name	First Name	Poster Title
1	Manning	Brian	Relationship between Patient Question Asking and Health Outcomes in a RCT
2	Hickner	John	Evaluation of an Emergency Department Primary Care Referral Program
3	Lin	Ge	Using geographic information to evaluate primary care physician demand
4	Dulin	Michael	Analysis of Healthcare Delivery to a Transitioning Community
5	McKee	M. Diane	Latinas with Diabetes Mellitus: Predictors of Poor Glycemic Control in a Low Income Primary Care Population
6	Day	Julie	Improving Care for our Patients with Diabetes: A System-Wide Approach
7	Fernald	Douglas	Designing a Patient-Centered Diabetes Registry: Successes and Challenges
8	Gaffney	Cecelia	Web-based Training Improved Smoking Cessation Counseling in Primary Care Practices
9	Kho	Abel	Informatics Solutions to Achieve Just-in-Time Subject Enrollment Across a Practice Based Research Network
10	Labuda Schrop	Susan	Profiles of Medically Underserved Patients Who Use Computer Kiosks to Learn about Preventive Health
11	Ariza	Adolfo	Testing a Computer System to Interpret Child Nutritional Health
12	Angier	Heather	Screening Kids in Lakeview for Developmental Delays (SKILDD)
13	Garbutt	Jane	What Constitutes Maintenance Asthma Care?
14	Eberl	Margaret	Primary Care Pathway to Improve Breast Diagnostic Care
15	Line	Laura	Pilot Studies That Have Helped Design Better Data Collection: Data Collection Tools for Practice-based Research
16	Crichlow	Renee	Established PBRN Patterns of Funding, Governance and Publication
17	Peterson	Kevin	Universal Modeling of Primary Care Clinical Trials
18	Miles	Toni	Studies of Research Readiness in Primary Care
19	Ryan	Alexandra	Evaluation of Bias in Consented Practice-Based Research
20	Pascoe	John	Attitudes Regarding Physician Counseling on Gun Safety Practices: A Comparison between Military and Civilian Parents
21	Sokolnicki	Annette	Primary Care Patients Self Reported Health Behavior Risks and Interest in Change
22	Robinson	Stacy	HHS Quick Guide to Health Literacy
23	Cardarelli	Roberto	Cardiovascular Disease, Perceived Discrimination, Social Support, and Sense of Personal Control
24	Anderko	Laura	Methylmercury Exposure Assessment within a PBRN
25	PBRN RC		About the PBRN Resource Center

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Relationship between Patient Question Asking and Health Outcomes in a RCT

Authors:

Brian Manning, MPH, CHES

Aaron J. Bonham, MS

James M. Galliher, PhD

Thomas V. Stewart

IC-DOV Research Team

Context:

Some research suggests patients who ask questions and actively participate in medical encounters have better health outcomes than less involved patients.

Objective:

1) Assess effectiveness of a brief intervention that encourages patient participation and question asking, and 2) evaluate whether question asking affects patient and physician communication and selected patient outcomes

Design:

RCT with 20 practices and two arms: 1) Practices implementing the Ask-Me-3 patient advocacy and health communication program, and 2) practices without the program.

Setting:

Twenty AAFP National Research Network practices from 18 states.

Participants:

Forty-one physicians and 829 patients.

Intervention or Essential Feature of Study:

Ask-Me-3 is a brief intervention to improve patients' contribution to communication during patient-physician visits. Practice staff distributed Ask-Me-3 brochures to patients at office visit check-in, encouraged them to read the brochure, and ask their physician questions. Physicians and patients completed post-visit questionnaires for each visit. Research staff attempted to re-contact patients who were prescribed medications for follow-up telephone interviews. Visits were audio recorded.

Outcome Measures:

Primary outcomes included: number of questions asked by patients, physicians' and patients' evaluation of visits and communication, patients' recall of physicians' prescriptions and lifestyle recommendations, patients' filling of prescriptions and attempts at modifying recommended lifestyles.

Results:

1108 patients invited and 829 (75%) enrolled (443 intervention & 386 standard care); 524 (87% of eligible) patients completed follow-up telephone calls. While some hypotheses were supported at the bivariate level, they did not remain statistically significant at the multivariate level ( $p > .05$ ).

Conclusions:

Use of the brief patient advocacy and health communication intervention for patients was hypothesized to have positive effects on question asking, patient and physician communication, and selected patient outcomes. However, results at the multivariate level provide little support for these hypotheses. Moreover, the hypothesis that enhanced patient question asking would be associated with health outcomes also was not supported.

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## Evaluation of an Emergency Department Primary Care Referral Program

### Authors:

John Hickner, MD, MSc

James Walter, MD

Maria Camargo, MSPH

Laura Derks, MSPH

Mary Pat Olson, RN, MSPH

**Context.** Having a primary care physician improves health outcomes and can decrease emergency department visits. The South Side Health Collaborative (SSHC), a consortium consisting of the University of Chicago Hospitals and 17 primary health care centers on the south side of Chicago, was formed in 2005 to connect UCH-ED patients with SSHC primary care providers

**Objective.** To evaluate the effectiveness of the SSHC in linking low income uninsured and underinsured UCH ED patients to a primary care provider.

### Design.

**Methods.** Trained lay patient advocates approach patients who were identified by the triage nurse as lacking a medical home. They schedule primary care visits at community health centers while the patient is in the UCH-ED or by phone following discharge.

**Setting.** The South Side of Chicago, which has a large medically indigent population.

**Participants.** Adults presenting to the UCH-ED who lacked a primary care medical home.

**Outcome Measures.** Percent of patients 1) approached by patient advocates who accepted referral services, 2) who accepted referral services for whom an appointment was scheduled, and 3) with appointments scheduled who showed up for the appointment.

**Results.** Of 44,422 patients seen in the UCH ED during the first 9 months of the program, 19,944 (45%) did not have a primary care physician. Of the 5,541 patients approached by the patient advocates 4,164 (75%) accepted a primary care referral to a SSHC health center of their choice and 1,816 (33%) had an appointment scheduled. 40% of patients who had appointments scheduled showed up for the appointment, 13% of the eligible patients seen by the patient advocates.

**Conclusions.** Referring ED patients who do not have a medical home for ongoing, community-based primary care is a challenging task. A substantial minority (25%) of ED patients who do not have a regular doctor do not want assistance in finding one. A small percent of eligible patients (13%) were linked with a primary care medical home. It remains to be proven if this program will lessen the load of primary care visits to the UCH ED. Further efforts will focus on improving the reach and efficiency of the program.



[top](#)

Title:

Using geographic information to evaluate primary care physician demand

Author:

Ge Lin, Ph.D

Dr. Spann Stephen

Dr. Andrew Bazemore

Dr. Robert Graham

Context:

The U.S. population has put pressure on physician demands that have largely unmeasured. This study uses a demographic accounting method to assess Texas primary care physician supply by county

Objective:

The paper intends to reexamine the current use of the gross population-to-physician ratio to measure shortages of primary health-care professionals and relate the measure to health outcomes (hospitalization). An adjustment of the current population-to-physician ratio according to age and sex is made and the result is compared with the existing designations based on the current criteria with the adjusted criteria. The proposed measure is easy to calculate and potentially can be incorporated into the designation criteria for shortage areas of primary health-care professionals.

Design:

Based on a GIS operation that matching avoidable hospitalizations with physician supply, head to head comparison of age-adjusted and the traditional methods have been carried out. It was found that that the standardized population-to-physician ratio tend to correspond to better with avoidable hospital admissions

Current Challenges:

If we adjust physician supply based on the new demographic accounting method, we may reduce the rate of avoidable hospitalization

Please describe the next steps you are planning for your study.

Write two papers on this issue.

Title: [top](#)

Analysis of Healthcare Delivery to a Transitioning Community

Authors:

Michael, Dulin, MD, PhD

Heather, Smith, PhD

Furuseth, Owen, PhD

Context:

Unprecedented growth of the Hispanic population in Charlotte, NC has created a novel set of forces converging upon the city's healthcare system and has subsequently challenged the capacity of local clinics despite predicted underutilization of primary-care services by this population.

Objective:

To utilize tenets of Community Participatory Research within a new Practice-Based Research Network in order to study healthcare delivery and potential disparities in healthcare access for the Hispanic population in the greater metropolitan area of Charlotte, NC. Results will be used to design interventions aimed at ameliorating disparities in healthcare access.

Design:

A group of ambulatory clinics designed to care for the disadvantaged population of Charlotte and the county health department are providing the clinical services expertise for the network. Three academic institutions with experience in Geographic Information Systems (GIS) and the Community-Oriented Primary Care model have created the research infrastructure. Community involvement has been incorporated extensively throughout the network. A Hispanic community advocacy organization has been instrumental in the network's design and implementation. A community advisory board has been established, and community member's feedback has been incorporated into the research design and data analysis. Qualitative data including feedback on the research process itself is being collected through community surveys and focus groups. Quantitative data on current healthcare access patterns is being mapped using GIS techniques to determine clinic service areas that can then be compared with known neighborhood demographics.

Current Challenges:

(1) Securing funding for the network. (2) Overcoming language and cultural barriers in recruiting community participants into the network.

Please describe the next steps you are planning for your study.

(1) Completion of qualitative data collection showing community perceived barriers to healthcare access. (2) Finish GIS mapping demonstrating current patterns of healthcare access. (3) Present qualitative and quantitative data back to the community and PBRN members to help design interventions aimed at improving healthcare access.

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Latinas with Diabetes Mellitus: Predictors of Poor Glycemic Control in a Low Income Primary Care Population

Authors:

M. Diane McKee, MD, MS  
Jeffrey Levine, MD  
Arthur Blank, PhD  
Jason Fletcher, MS  
Nellie Fernando, MS  
Eliana Korin Dipl.Psych.  
Charles E. Schwartz, MD

Context:

Type 2 diabetes mellitus (DM) is more common among Latinos than among non-Hispanic whites and control of blood sugar is less successful. A clear understanding of how psychosocial issues affect diabetes control is lacking for low-income Latinas.

Objective:

We explored the influence of family environment and mental health on glycemic control for Latina women to inform development of primary care.

Design:

Interviewer-directed survey.

Setting:

Family medicine practices in the Bronx serving low income patients.

Participants:

Latina women with at least two office visits in the previous year, defined as out of control (HbA1C > 9.5 on two occasions) or in-control (HbA1C less than 7.5).

Intervention or Essential Feature of Study:

Analyses compared women with out-of control DM (OC; n=40) and in-control DM (IC; n=62) to identify predictors of glycemic control.

Outcome Measures:

Depression (PHQ), Bipolar Illness (MDQ), Regimen Specific Social Support, Problem Areas in Diabetes (PAID), Family Cohesion and Conflict, Familism, Stanford Physician Trust, and Health Literacy.

Results:

Women with out-of control DM and in-control DM were similar demographically. Health literacy was lower than the general population (mean 26.8). PHQ scores  $\geq 10$ , compatible with clinically significant depression, were present in 29% of subjects but did not differ between groups. The proportion with MDQ  $\geq 7$ , compatible with bipolar spectrum disorders, was higher in the OC group (35.9% vs 14.5%,  $p=.02$ ). The PAID scale indicated greater diabetes distress in the OC group (38 vs 25,  $p=.046$ ). PHQ and PAID scores were highly correlated ( $R=.74$ ). Family cohesion scores were high and family conflict moderate but not discriminating of glycemic control. Analysis of PAID by question suggested that IC subjects had greater optimism and self-efficacy, but multivariate analyses did not result in stable models discriminating IC and OC groups in these domains.

Conclusions:

Significant levels of depression were found in nearly one-third of subjects whether IC or OC. Bipolar disorders may be more common among OC subjects. Further studies to understand and improve diabetes outcomes in Latino women should focus on psychological factors in addition to depression, particularly bipolar disorders and the presence of potential protective factors such as optimism and self-efficacy.

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Improving Care for our Patients with Diabetes: A System-Wide Approach

Authors:

Julie Day, MD

Earl Hodgkins, BS

Annie Sheets Mervis, MSW

Context:

Reducing complications of diabetes is a high priority to improve quality of care.

Objective:

Improve the care of patients with diabetes, by designing, implementing, and evaluating EMR-based tools and a diabetic registry to assist providers in identifying and managing their population of patients with diabetes.

Design:

Longitudinal study before and after implementation of a diabetes quality improvement program.

Setting:

University of Utah Health Care: Community Clinics (UHCC), a 100,000 patient, seven-practice, multi-specialty, primary care network, linked by electronic medical record (EMR), located in and around Salt Lake City, Utah

Participants:

Patients with diabetes, age ≥ 16 years.

Intervention or Essential Feature of Study:

- . EMR-based template for diabetes visit with built-in electronic orders.
- . EMR-based Flow Sheet Report summarizing history of lab results and referrals
- . Disease registry .
- . Outreach letters to patients

Outcome Measures:

Percent of patients with HgbA1c ordered twice annually, LDL and microalbumin ordered at least annually, HgbA1C < 7%, LDL < 100, and BP controlled at < 130/80.

Results:

Results for 2570 patients seen Feb 2003 - Jan 2004 were compared to results for 2719 patients seen June 2004 - May 2005. Statistically significant ( $p < .002$ ) improvements included: HgbA1c ordered twice annually increased from 71% to 75%, LDL ordered annually increased from 74% to 81%, microalbumin ordered annually increased from 54% to 63%, LDL values < 100 increased from 28% to 41%, and BP < 130/80 increased from 28% to 34%. Patients with HgbA1c values < 7 increased from 47% to 49.5%, but change was not significant.

Conclusions:

The interventions were associated with improvement in process and outcome measures. However, identifying the provider primarily responsible for managing diabetes is an ongoing challenge in producing registries. Providers need additional resources to consistently use the registries and conduct outreach activities.

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## Designing a Patient-Centered Diabetes Registry: Successes and Challenges

### Authors:

Douglas H. Fernald, MA  
Anne Kinney  
Leah Haverhals MA  
Greg Higgins  
Steve Ross MD  
Bennett Parnes MD  
Wilson Pace MD  
Elizabeth Staton MSTC  
Deborah S. Main PhD.

### Context:

Chronic disease registries are viewed as essential to improve chronic care yet they are difficult to implement and sustain in primary care offices.

### Objective:

To determine the feasibility and impact of an automated, patient-centered diabetes registry for improving guideline-concordant diabetes care and patient self-management.

### Design:

We adopted an innovative quality improvement model for engaging practices and all patients with diabetes in this project. We designed an automated system for ongoing population of a registry using existing clinical information (from billing, diagnostic and scheduling systems) and regular data collection from patients with diabetes (via web, automated telephony system or paper) about diabetes self-management activities. To help clinicians and patients plan their visits, patients receive reports about their own status with respect to guideline-concordant diabetes care along with information about their diabetes. Primary care offices receive a condensed version of this patient-level diabetes summary.

### Current Challenges:

**Successes:** The patient-centered diabetes registry has been well received by primary care practices and by patients with diabetes. Their involvement in developing the registry interfaces, measures and reports improved the system for communicating with patients, clinicians and practices about diabetes care, and enhanced methods and tools to expand the registry for other chronic conditions and to sustain it beyond current funding.

**Current Challenges:** Despite the receptivity of critical end-users of this system (i.e., practices, clinicians and patients), we have had challenges resulting in significant delays in "rolling out" the system in pilot practices. Key challenges include: turnover in programmers, limited capacity for data transfer in one system, use of outside vendor for telephony portion of the system, and initial reluctance of a hospital system to define this as a quality improvement rather than research project. Despite these challenges, we expect the registry to go "live" within the next two months.

Please describe the next steps you are planning for your study.

We will "go live" within the next two months and will refine our communication processes and reports for patients and practices.

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## Web-Based Training Improved Smoking Cessation Counseling in Primary Care Practices

Authors:

Cecelia A. Gaffney, MEd

Cathy L. Melvin, PhD

C. Tracy Orleans, PhD

Context:

Moderate increases in likelihood of successful implementation of evidence-based interventions (EBI) have resulted from on-site training such academic detailing. These approaches are expensive and difficult to implement in busy practices.

Objective:

Can a web-based interactive, self-directed program result in office system changes and increased counseling?

Design:

Patient exit interviews, chart audits and clinician surveys were collected prior to the practice viewing the program and three months after they reported implementing changes based on their viewing of the program.

Setting:

Six rural primary care practices in New England participated in a study of the impact of completing the program on clinician skills and office system changes.

Participants:

All women ages 18-45 years who presented for care were asked to complete an exit survey during two data collection periods. All clinicians and staff at participating practices completed program evaluations and self-reported behaviors.

Intervention or Essential Feature of Study:

A multi-media training program, "Smoking Cessation for Pregnancy and Beyond: Learn Proven Strategies to Help Your Patients Quit," offered case simulations and discussions, mini-lectures, patient interviews, tools for changing office systems and web resources. The tools accommodate different learning styles. Topics presented assured that information needed by all staff to perform different roles was provided. Individual learning occurred at each person's convenience and pace rather than requiring the entire staff to meet as a group. Participants could earn continuing education credits.

Outcome Measures:

Patient reported receipt of the 5 A's, documentation of 5 A's in random charts at most recent visit and clinician self-report of providing counseling based on the 5 A's.

Results:

Patients reported significant increases in assessment of smoking status ( $p=.02$ ) and of exposure to second hand smoke. Patient reported assistance with quitting and arranging follow-up increased by not significantly. Self-report by clinicians found a significant increase in assisting with quitting ( $p=.008$ ) and arranging follow-up ( $p=.03$ ).

Conclusions:

Three quarters of staff and clinicians found that the program contained enough information to implement the EBI. A well-designed interactive training program can increase provision of EBI.

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Informatics Solutions to Achieve Just-in-Time Subject Enrollment Across a Practice Based Research Network

Authors:

Abel Kho, MD MS  
Brenda, Hudson, MA  
Jane French  
Mike Litherland  
William Tierney, MD

Context:

Practice Based Research Networks (PBRNs) typically involve geographically dispersed practices which complicates screening, enrolling, and following of research subjects. Electronic health records (EHRs) can provide solutions.

Objective:

- 1) Use informatics expertise and an EHR to efficiently enroll subjects in a PBRN.
- 2) Identify eligible subjects from patients' EHRs despite Open Access (i.e. same day) patient scheduling.

Design:

Before and after interventional study.

Setting:

Indiana University Medical Group's PBRN (ResNet) covering 17 primary care sites.

Participants:

ResNet involves an even mix of commercial and indigent populations and employs three full time research assistants.

Intervention or Essential Feature of Study:

In 2005, IUMG instituted Open Access scheduling of appointments. Open Access necessitated a system for real-time communication between the scheduling system and research assistants enrolling patients for multiple studies. We implemented an open-source software application to receive electronic appointment notices from ResNet clinics and automatically match registered patients to a list of eligible patients. Research assistants verify patient eligibility from this dynamically updated list and tailor recruitment at the various clinics based on numbers of eligible patients visiting.

Outcome Measures:

Number of eligible research patients screened

Results:

Since 1999, ResNet has screened over 18,000 patients and recruited over 6,000 subjects for over 30 studies with more than \$15 million in extramural direct cost funding. Fewer than 2% of potentially eligible patients were missed prior to the institution of Open Access. Our software solution enabled research assistants to resume electronic screening of eligible patients and maintain pre-Open Access levels of recruitment efficiency.

Conclusions:

- 1) Informatics tools can greatly increase the efficiency of subject recruitment and expand the reach of a limited pool of research assistants.
- 2) Electronic registration messages present an opportunity for the automatic capture of appointment data. This open source solution can be a useful adjunct, or stand alone application for subject enrollment in PBRNs.

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Profile of Medically Underserved Patients who Use Computer Kiosks to Learn about Preventive Health

Authors:

Susan Labuda Schrop, M.S.

Brian F. Pendleton, Ph.D.

Gary McCord, M.A.

Context:

Delivering patient education concerning preventive health in clinics for the medically underserved and ensuring patient adherence to recommendations can be difficult due to provider and patient barriers.

Increasing patient-provider discussions is an important first step to increasing healthy behaviors.

Objective:

The purpose of this study is to determine the effect of a computer-based intervention on physician-patient discussions regarding smoking, exercise, weight control and alcohol use.

Design:

Touch-screen computer kiosks for patients' use were placed in the waiting rooms of clinics for the medically underserved. The program consists of demographic questions, comorbidities, patient's status regarding cigarette smoking, alcohol intake, exercise and maintaining a healthy weight, and willingness to modify their behavior. Targeted preventive health messages are provided with an option to print two copies – one for the patient and one to share with the health care provider to stimulate discussion about healthy behaviors.

Setting:

Six community-based clinics for the medically underserved in Northeast Ohio.

Participants:

Adults who visited the participating clinics and used the computers.

Outcome Measures:

Profiles of kiosk users including demographics, comorbidities and stage of change for target behaviors, and frequency of provider/patient discussions regarding the target behaviors as reported by patients in exit interviews.

Results:

This poster presents the profile of kiosk users. The program has been accessed by 5,276 users with an average age of 38. Almost 63% were female, 61% were Caucasian, and 60% had a high school education or less. Users had an average BMI of 29.6, and the top four comorbidities reported were weight problems (41%), sleep problems (40%), depression (39%) and tobacco use (38%). The topic of most interest was weight control (44%), followed by cigarette smoking (24%), exercise (18%) and alcohol intake (14%).

Conclusions:

Data from the computers indicate that patients use the computer and are interested in preventive health. Data from exit interviews and chart reviews will be used to determine the effect of the computer and preventive health messages on discussions between patients and providers.



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## Testing a Computer System to Interpret Child Nutritional Health

### Authors:

Adolfo Ariza, MD  
Sherry Lyons, MA  
J. Scott Thompson  
Jeremy Samkowiak  
Helen Binns, MD,MPH

### Context:

Child growth interpretation is a recommended aspect of pediatric health supervision visits (HSV).

### Objective:

To implement and evaluate a new computer system to aid child growth interpretation and health counseling in pediatric practice.

### Design:

Pre- and post-intervention evaluation.

### Setting:

Two diverse PPRG practices. One practice serves mostly privately-insured patients and the other is a community health center serving low-income families.

### Participants:

HSV of children aged 2-10 years were observed. Practice members were interviewed.

### Intervention or Essential Feature of Study:

Health Indicators Analyzer (HIA) software to assist with nutritional health interpretation, growth tracking, and printing of educational handouts was implemented; its adoption of use was determined by the practice.

### Outcome Measures:

Visit time and content (assessment and counseling), identification of overweight ( $\geq 95$ th BMI percentile, OW), parental satisfaction with visit, and clinician response. Analyses adjust for practice clustering, where possible.

### Results:

62 visits were observed pre and 40 visits post (23 no HIA, 17 with HIA). 65% were visits of children 2-5 years; 16% with an OW child. Time for single child visits did not vary by intervention group (overall: Practice A, 41 minutes; Practice B, 33 minutes). Physicians identified abnormal weight pattern among OW children in 7/9 pre, 0/1 post no HIA, and 4/6 post with HIA visits; (unadjusted Fisher's Exact,  $P=.374$ ). Time to address growth significantly increased when the HIA was used (median seconds: 38 pre, 30 post no HIA, 136 post with HIA;  $P<.01$ ); however, the percent of parents very satisfied with growth information significantly decreased (84% pre, 71% post no HIA, 41% post with HIA;  $P=.03$ ). Physicians' reported that the HIA improved parental and child recognition of OW.

### Conclusions:

Implementing the HIA changed care delivery. Further evaluations are needed to clarify HIA impact on care delivery, child health outcomes, and responses of clinicians and parents.

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## Screening Kids in Lakeview for Developmental Delays (SKILDD)

### Authors:

Heather Angier, BA, CCRP

Lyle J. Fagnan, MD

Cynthia Morris, MD, PhD

### Context:

Studies show that up to 20 percent of all children will have a behavioral development issue, yet few children are identified as needing care and even less receive necessary treatment. A recent study found that although most physicians are committed to the early diagnosis of developmental delay there is considerable variability in surveillance and screening practices. There are no published studies regarding screening, assessment, and referral of children for behavioral risks in rural primary care practices.

SKILDD is a quality improvement(QI)project undertaken by two Lakeview, Oregon primary care practices. These practices have enhanced the well child visit by instituting a standardized screening process and an explicit referral process.

### Objective:

There are three main study hypotheses:

- 1.Implementation of evidence-based screening tools as part of a well-child visit will increase the rate of identification and referral of children at risk to appropriate community resources.
- 2.Integration of a case manager model, an Early Intervention Family Coordinator(EIFC), into the primary care office setting will increase the rate of referral follow through.
- 3.The screening and referral process will be accepted and valued by clinicians, staff, and patients.

### Design:

To assess the feasibility of the QI project, a comprehensive chart review will be conducted 6 and 12 months after the standardized screening process begins. We will track and measure the percentage of children who are screened, the percentage of children and families referred for intervention, and what happens after referral.

To assess satisfaction, a researcher from the Child and Adolescent Health Measurement Initiative (CAHMI) has conducted in-person key informant interviews with the EIFC, and the physicians and office staff from the clinics involved in SKILDD. Also, several parents who have participated in the screening process have been interviewed.

### Current Challenges:

The current challenges of the QI project include: information dissemination, screening differences between the two primary care clinics, and a lack of communication regarding referral follow up.

### Questions for Audience Consideration:

To share our experience with evaluating a QI project that includes numerous collaborators.

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What Constitutes Maintenance Asthma Care?

Authors:

Jane Garbutt, MB,ChB

Randy Sterkell, MD

Jay Epstein, MD

Suzanne Wells, RN

Lisa Swerczek, BSN, RN

Christina Banister, BA

Gordon Bloomberg, MD

Context:

Scheduled maintenance care for asthma is considered an effective intervention in prevention of exacerbations and need for emergent care.

Objective:

To understand what activities pediatricians include in maintenance asthma care.

Design:

Cross-sectional survey of community pediatricians

Setting:

PBRN of community pediatricians in St. Louis, MO

Participants:

Most respondents were experienced community pediatricians (mean years in practice 14.7), worked in group practices (61%) and were located in the suburbs (63%).

Intervention or Essential Feature of Study:

Between June and October 2005, 135 community pediatricians completed a 34-item questionnaire about routine care for children with persistent asthma between 5 and 12 years old. The survey response rate was 60% (135/225).

Outcome Measures:

Median percent of patients prescribed treatment, or percent of pediatricians who included the activity in maintenance asthma care.

Results:

Pediatricians prescribed inhaled corticosteroids for most patients with persistent asthma (median 80%). Of the 135 respondents, most asked questions about recent use of rescue medications (96%), emergent care (91%), and controller medications (96%) to assess and monitor asthma severity. While only 6% of pediatricians believed that the majority of their patients (> 80%) used their controller medicines as prescribed, few asked probing questions to assess medication adherence, such as how often doses were missed (49%), and if doses were missed on the weekend (20%). Pediatricians were less likely to include activities to support self management such as annual review of an asthma action plan (63%), setting asthma care goals (60%), or asking about the impact of the child's asthma on the parent and family (24%).

Conclusions:

Although pediatricians prescribed effective controller medications for children with persistent asthma, most believed that their patients did not use these medications as prescribed. Helping pediatricians to redesign how they provide maintenance asthma care may increase patient use of effective asthma treatments and improve patient outcomes.

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## Primary Care Pathway to Improve Breast Diagnostic Care

### Authors:

Margaret M. Eberl, MD, MPH

Chester H. Fox, MD

Martin C. Mahoney, MD, PhD, FAAFP

Nancy Watroba

Stephen B. Edge, MD

### Context:

Initial diagnostic testing is a critical component of breast cancer treatment, but up to 30% of women with abnormal findings on mammography do not get appropriate follow-up evaluation. Women with BIRADS code 3 require 6 month follow up and women with BIRADS 4 and 5 need prompt biopsy. Competing demands in a busy practice environment suggest that primary care physicians need improved systems for dealing with low frequency events such as abnormal mammograms. A multi-faceted practice intervention, consisting of automated monitoring using administrative claims data, primary care physician notification, and provision of a care pathway, can improve the rate of optimal follow-up of abnormal mammograms.

### Objective:

To determine the impact of a multi-faceted practice-based intervention (utilizing electronic medical record monitoring, standardized physician care recommendation pathway, physician notification and care management) to enhance optimal follow-up testing for abnormal mammograms. This electronic record case management system should be exportable to any medical practice with electronic records and to any claims-based administrative system.

### Design:

A practice intervention using automated electronic record monitoring, coupled with primary care physician notification of mammogram findings, care pathways, patient education for abnormal mammograms. The study is being conducted in a large medical practice with 6 locations. The electronic record is being monitored for BI-RADS code for each mammogram and being matched with claims data from the payer. Care is then being monitored by claims data to assure appropriate follow-up. The results of this intervention will be measured against specific outcomes measures for BI-RADS 0, 3, 4 and 5 mammograms compared to women in the 4 preceding years.

### Current Challenges:

The biggest challenge is physician education and buy-in. This is being addressed at routine provider meetings. Distinguishing between tests not being ordered and tests not being completed due to patient refusal is important and will be tracked.

Please describe the next steps you are planning for your study.

If the current study, once completed, is shown to be successful in improving breast diagnostic care, we will make plans to disseminate the system to the Western New York region.

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Pilot Studies That Have Helped Design Better Data Collection: Data Collection Tools for Practice-based Research

Authors:

Nancy Rothman, Ed.D, RN

Laura Line, MS

Context:

In our practice-based research network we are working to build an evidence base for the services our nurse-managed health centers provide and the programs that address significant problems in the communities we serve. In the several years of collecting and analyzing data on these services and programs, we have learned a great deal about useful tools for data collection and their implementation in practice settings. We believe sharing these tools and recommendations will improve evidence-based practice.

Objective:

To share primary care practices and project outcomes, along with issues and recommendations specific to data collection in order to improve evidence-based practice in PBRNs.

Design:

Present evaluation studies and results for primary care services and in three programs implemented in our PBRN. Discuss data collection tools and data collection issues that arose and how we were able to address these issues.

Setting:

Our PBRN, the Data Mart Network, consists of eight community-based primary care centers managed by nurse practitioners in collaboration with physicians. These centers are based in the Philadelphia area and serve an un- or under-insured population across all ages, consisting primarily of african-americans and latinos. The centers provide a range of primary care services including prenatal and behavioral health services. Seven are urban-based and one is rural. The Data MArt Network is currently transitioning to an Electronic Medical Record system and has engaged in a number of research studies to date.

Participants:

Clients of nurse-managed health centers. The participants vary according to each program or service.

Intervention or Essential Feature of Study:

This is not a study. It is analyzing data collection instruments and data collection processes used in program evaluation towards future evidence-based practice.

Outcome Measures:

The presentation shares program evaluations outcomes: e.g. Lower blood lead levels, Reduced cases of asthma, Reduced anxiety and depression, Utilization of services as we discuss the tools and processes used to collect and understand these outcomes.

Results:

Pilot studies and improved data collection has allowed us to move to research studies demonstrating impact and effectiveness of interventions.

Conclusions:

Program evaluation can provide preliminary data to be used for practice-based research, especially in the area of developing better data collection tools and better data collection processes.

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Established PBRN Patterns of Funding, Governance and Publication

Authors:

Renee, Crichlow, MD FAAFP

Robert, Lininger, BS

Laura, Dimmler, PhD-C

Context:

The Federation of PBRNs has among there membership some of the more active PBRNs in the country. Each voting member PBRN must have conducted at least one study, be a primary care network, primarily located within the United States, and have a provision for membership governance. As a developing PBRN our intention was to evaluate and understand the patterns of funding, governance and publication of established PBRNs.

Objective:

To evaluate what funding sources have sustained PBRN practice to date

To determine spectrum of governance in PBRNs

To evaluate patterns of publication and demonstrate which journals have published PBRN research

Design:

Cross-Sectional Survey of Practice Based Research Networks

All 54 member PBRNs from the Federation of Practice-Based Research Networks were surveyed, data gathered, and preliminary results tallied. Information gathered included composition of membership; number of clinicians/practices/patients served per member network; governance and ownership of PBRNs; most common funding sources; topics of research; pertinent papers published/national presentations given as a result of that research.

Current Challenges:

Current challenges include completing Systematic Review of all journal publications of research from the membership of the FPBRN and categorizing these as to the types of PBRN studies involved

Please describe the next steps you are planning for your study.

We are systematically gathering the published research of the Federation of Practice Based Research Network membership with the hopes of categorizing these studies and subsequently determining if there are patterns to the types of studies and publications that may come from a particular composition of PBRN funding and governance.

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## Universal Modeling of Primary Care Clinical Trials

Authors:

Peterson, Kevin MD

Delaney, Brendon MD

Arvenitis, Theo PhD

Context:

We are developing tools to assist in the development of primary care trials. Our first step in this is to model the development and performance of a clinical trial and translational study using Universal Modeling Language. Current models from CDISC and HL7 are designed primarily from the perspective of typical pharmaceutical trials, and do not address problems that are encountered in the primary care environment.

Objective:

It would be valuable to receive feedback on the current models that we have developed to see if there are additional features that need to be included. This group would be valuable in addressing other types of use cases that are encountered in primary care.

Design:

This is part of the ePCRN study. We are first developing tools that model the development of clinical trials. We will then match these to the National Library of Medicine UML vocabulary to provide semantic interoperability. We will then develop tools that will generate ASP pages for standardized reporting forms for use in trials.

Current Challenges:

Development of modeling that is consistent with existing CDISC and RIM models, but encompasses use cases found in primary care.

Questions for Audience Consideration:

Provide input on the models that we have developed. Are there other use cases that are needed in the modeling.

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## Studies of Research Readiness in Primary Care

### Authors:

Toni, Miles, MD, PhD

Sharon, Barrer, RN

Maggie, Steptoe, MLS

Brian, Briscoe, BA

Sukee Kim, MSW

Stephanie, Garrett, MD

### Context:

We are in the process of recruiting practices to develop a PBRN in our area. We are seeking to build a network that is representative of the primary care sites in a 16 county area including metropolitan Louisville, Ky and points west. We are also interested in developing methods that permit data collection during the process of care delivery without disruption of the visit. Finally, we are interested in measuring staff experience and attitudes surrounding the conduct of research in their workplace.

### Objective:

#### Questions:

1. Can we efficiently collect 'pen and paper' survey data from patients in the exam room? This survey is a clock drawing task to screen for cognitive impairment.
2. Can we efficiently conduct a record linkage study between the practices and the Kentucky Cancer Registry?
3. Can we efficiently recruit patients for a study involving collection of blood samples?
4. How does the staff view the conduct of research before and after these studies are completed at their sites?

### Design:

To recruit practices for this network, we started with university-based primary care sites (7) and then extended our outreach to the institutions that provide care to the largest proportion of persons in our area - the Federally Qualified Health Centers (2 sites), the Veterans Administration (5 sites), private corporations (2 sentinel sites in the 36 site Norton Healthcare System, 2 sites in the Baptist Healthcare System). Together these practices serve almost 500,000 persons in the 1.2 million metropolitan area. They also cover the spectrum of socioeconomic status and ethnicity.

### Current Challenges:

1. Obtaining funding to continue this process.
2. The lack of electronic medical records.
3. Physicians at the sites are very welcoming but the pressure to see patients and the fact that many of them are 45 years and older pose a significant challenge to fully engaging them in the PBRN process. To facilitate information flow we have implemented a process for returning data to the practice within a month of completing data collection.

Please describe the next steps you are planning for your study.

#### Next steps:

1. Complete the cognitive impairment prevalence estimate within the next 3 months.
2. Send data from 4 test sites to the Kentucky Cancer Registry for linkage with the NCI-SEER. The reports from SEER will be returned to the practices so that physicians will have documentation for cancer survivors.
3. Complete the Pharmacogenetics Allelic Variation study in 2 test sites. This study will return practice-level genetic variation data for the 3 P450 enzymes that are responsible for almost 70% of all drug metabolism.



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Evaluation of Bias in Consented Practice-Based Research

Authors:

Alexandra Ryan, MD

Roopa Seshadri, PhD

Helen Binns, MD, MPH

Context:

Consent procedures and the anticipated burden of data gathering may introduce bias into research studies.

Objective:

To identify differences between families who consented for study participation and those who provided anonymous data only.

Design:

Cross-sectional survey.

Setting:

13 diverse practices of the Pediatric Practice Research Group.

Participants:

Consecutive sample of parents/guardians bringing children for care.

Intervention or Essential Feature of Study:

Parents were asked to consent to provide information on family health behaviors by an in-office survey, 4 telephone calls, and review of their children's medical records. Those not consenting could complete the survey anonymously.

Outcome Measures:

Scores were developed for health behaviors and opinions on pediatrician counseling. Health behaviors were grouped by number of healthy behaviors reported (0, 1, 2, 3-5). Generalized linear models with random effect for practice were used to select factors differing between consented and anonymous groups at  $p < .10$ . These factors were entered in a multivariate model.

Results:

Among 6617 eligible subjects approached, 4218 (64%) provided consent and 688 (10%) completed the survey anonymously. Subjects were: 89% mothers; 48% white, 13% African American, 34% Hispanic, 5% other; and 43% Medicaid/uninsured. In the multivariate model, subjects who consented were more likely to be mothers (odds ratio [OR] 1.4, 95% confidence interval [CI] 1.1-1.8), aged  $\leq 25$  years (compared to 40+ years; OR 1.5, 95%CI 1.1-2.1), and Medicaid/uninsured (OR 1.3, 95%CI 1.0-1.7) and less likely to be of "other" race/ethnicity (compared to Hispanics; OR 0.6, 95%CI 0.4-0.9). Groups reporting few or many healthy behaviors consented less often than those who reported no healthy behaviors (OR 0.7, 95%CI 0.5-0.9 for all contrasts). Intraclass correlation for practice was 3.3%.

Conclusions:

Significant differences exist between parents who consent to participate in practice based research and those who refuse. These differences may be unique to the research process and need consideration when performing practice based research.

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Attitudes Regarding Physician Counseling on Gun Safety Practices: A Comparison between Military and Civilian Parents

Authors:

John M. Pascoe, MD, MPH  
Shalini G. Forbis, MD, MPH  
Adrienne Stolfi, MSPH  
Christopher A. Schlorman, BS  
Terence R. McAllister, MD

Context:

There may be important differences in parental attitudes between civilian and military parents' attitudes and behaviors regarding firearms.

Objective:

To compare gun storage and safety attitudes and behaviors between military and civilian parents

Design:

Cross-sectional, two-page survey about parental firearms attitudes and behaviors

Setting:

Dayton Primary Care Practice-Based Research Network (PBRN) includes the primary care pediatric practice at Wright Patterson Air Force Base (N=574) and civilian pediatric practices in the Greater Dayton area (N=451)

Participants:

Convenience sample of parents whose children receive their primary health care from practices within the Dayton Primary Care PBRN

Intervention or Essential Feature of Study:

N/A

Outcome Measures:

N/A

Results:

Military parents (MP) were more educated, 85% > high school education (civilian parents [CP] 52% > HS education,  $p=0.00$ ). 18% of CPs and 27% of MP reported at least one gun in the home ( $p=0.00$ ). CPs were more likely to report that the child's doctor had talked about guns than MPs (11% v 6%,  $p=0.00$ ). CPs were also more likely to believe that physicians should ask about guns in the home (78% v 61%,  $p=0.00$ ), advise about gun storage (88% v 64%,  $p=0.00$ ) and advise about removal of guns from the home (48% v 24%,  $p=0.00$ ). MPs were more likely to report that the child had been taught gun safety by a parent (93% v 77%,  $p=0.00$ ). However, children of CPs were more likely to be taught gun safety through a formal course (17% v 7%,  $p=0.00$ ). All of the above differences remained significant and in the same direction when solely analyzing parents who had guns at home.

Conclusions:

Civilian parents are more likely to believe that physicians should ask about gun presence and advise about gun storage than military parents. Military parents are more likely to report that children have been taught gun safety by a parent.

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## Primary Care Patients Self Reported Health Behavior Risks and Interest in Change

Authors:

Annette Sokolnicki, BS

Jodi Holtrop, PhD

David Weismantel, MD,MS

Context:

The health behaviors of tobacco use, physical inactivity, unhealthy diet, and risky alcohol drinking are the top causes of death in the U.S. Assessments of patient's risks and interests in behavioral improvement in these areas is needed within primary care. This data is collected as the baseline assessment of a study to test the use of a practice referral system for connecting with community health behavior resources in three communities in Michigan.

Objective:

The aim of the project is to evaluate the self-reported health behavior risks of patients and their interest change.

Design

The survey assesses basic demographic information, height, weight, age, gender, risk regarding the four behaviors, and if at risk, interest in change.

Settings:

A health behavior patient survey is being distributed to 200 consecutive adult patients in 15 GRIN practices. The practices vary from rural population to urban/suburban population and have a wide range of socioeconomic characteristics.

Participants:

Male and female adult patients presenting for a visit in one of the study practices.

Current Challenges:

- 1) Prevalence of tobacco use, physical inactivity, unhealthy diet, and risky alcohol drinking in the participating practices.
- 2) Patient's interests in making health behavior improvements.
- 3) Relationship of health behaviors to demographic and background characteristics including gender, age, educational level, and BMI.

Please describe the next steps you are planning for your study.

The surveys are being completed as part of the Prescription for Health (P4H) initiative funded by the Robert Wood Johnson Foundation. In Michigan, our P4H project is titled the CHERL (Community Health Educator Resource Liaison) Project. The aim of the CHERL project is it to determine if providing a CHERL helps practices help their patients change risky behaviors by connecting patients to available services in the community or directly providing behavior change support. This baseline survey provides a snapshot of each practice's patient population, and will inform practices of their "at risk" patient population and interests in change.

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HHS Quick Guide to Health Literacy

Authors:  
Stacy Robison MPH, Cynthia Baur PhD, Carmela Lomonaco PhD

According to the Institute of Medicine, approximately one-half of the adult population lacks the needed literacy skills to use the U.S. healthcare system. Low literacy has been linked to poor health outcomes. Studies demonstrate that patients with high blood pressure, diabetes, asthma, or HIV/AIDS who have limited health literacy skills have less knowledge of their illness and its management. Several studies have shown that individuals with limited health literacy have lower adherence to anticoagulation therapy and worse glycemic control. Patients with limited health literacy skills may have difficulty with seemingly simple tasks such as reading a prescription drug label. These same patients are routinely encountered in clinical settings, positioning primary care providers on the front lines of this public health challenge. It is critical that primary care providers consider health literacy skills in their research and practice. The *Quick Guide to Health Literacy* was developed by the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services and contains information for primary care providers on how to incorporate health literacy improvement into clinical practice. The strategies in the *Quick Guide* reflect the current body of research in health literacy and health communication, including the use of plain language, culturally and linguistically appropriate communication, user-centered design for information and services, evaluation of communication effectiveness, and advocacy. To date, responses to the problem of low health literacy have focused on individual level factors that create barriers to improved health literacy. Although these efforts are critical, improving health literacy requires *systemic* changes to healthcare and public health practice. The *Quick Guide to Health Literacy* includes tools for primary care providers to assess the impact of health literacy on their practice and identify appropriate systems-level interventions to improve the health literacy of their patients.

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Cardiovascular Disease, Perceived Discrimination, Social Support, and Sense of Personal Control

Author:

Roberto Cardarelli, DO, MPH

Kathryn Cardarelli, PhD

Ana Chiapa, MS

Context:

Accruing evidence supports the hypothesis that psychosocial factors are related to cardiovascular disease (CVD) mortality and morbidity. However, a limited number of studies have investigated the pathophysiologic pathways and mechanisms through which these associations occur. Small but sustained elevated levels of glucocorticoids may be associated with hypertension, increased lipid levels, and insulin resistance, all known risk factors for CVD. Perceived discrimination, social support, and sense of control may be psychosocial factors that contribute to CVD. Studies have found that women who reported more experiences of discrimination were more likely to have coronary artery calcification, compared to women who did not experience discrimination. Social support in times of stress has been found to attenuate blood pressure and cortisol reactivity, while low support was associated with higher epinephrine levels. Therefore, a more thorough understanding of the association between psychosocial factors and cardiovascular pathophysiologic mechanisms and pathways is needed.

Objective:

To assess whether experiences of perceived discrimination, social support, sense of personal control, and other psychosocial factors are associated with cardiovascular serum markers and calcium scores.

Design:

The study uses a cross-sectional design and involves 4 different testing procedures. An interview will take place using previously validated instruments that measure perceived discrimination, social support, sense of control, and other psychosocial factors. Lab analysis will include a complete metabolic panel, standard lipids and traditional/ emerging risk factors for CVD. Calcium scores will be obtained through a multi-slice CAT scan. A total of 200 participants will be recruited from member clinics throughout the North Texas area.

Current Challenges:

Completing the IRB process.

Please describe the next steps you are planning for your study.

Finalize study procedures, obtain IRB approval, and start the study.

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Methylmercury Exposure Assessment within a PBRN

Author:

Laura Anderko RN PhD

Context:

Mercury is a highly toxic metal that poses a serious threat to health. Dietary fish intake is the most important source of human exposure to methylmercury. Because of the increased popularity of fish as a source of dietary protein, a significant percentage of the U.S. population may be at risk of methylmercury-induced health problems. Nearly 90% of the U.S. population consumes fish on a regular basis and the EPA estimates that over 600,000 children born every year are exposed to unsafe levels of toxic mercury in utero.

Objective:

This study is designed to evaluate fish consumption patterns and mercury body burdens among clients of selected member agencies located in the Great Lakes Region, for the Midwest Nursing Centers Consortium Research Network (MNCCRN) an AHRQ sponsored PBRN. Correlations of fish consumption with body burdens, as well as comparison of body burdens among clients to national exposure data (e.g., NHANES) will be conducted.

Design:

The proposed study will be based on a pilot study conducted by selected MNCCRN centers in 2004/2005. Health professions students will participate in the screening effort, and will receive training on environmental exposure assessment and screening procedures. All center clients will be asked about their interest in participation and consented. A brief dietary questionnaire will explore: Fish consumption (type of fish and quantity of fish consumed per meal) and any self-reported neurological complaints. Hair samples will be collected and analyzed to determine levels of methylmercury.

Current Challenges:

Multiple IRB protocols across several academic nursing centers and selection of labs for conducting the hair analyses.

Goals for Session/Questions for Audience Consideration:

To explore the potential interest of primary care providers to assess for methylmercury toxicity and a proposed PBRN study based on pilot study findings that includes student training for methylmercury exposure assessment and screening in primary care settings.

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Bratzler	Dale		QI Plenary
Bolling	Christopher	CPRG	IIB - Pediatric Research
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McCann	Mary Ellen		Monday Operations Workshop
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Pascoe	John	Dayton Primary Care PBRN	IIB - Pediatric Research
Pascoe	John	Dayton Primary Care PBRN	Poster
Peterson	Kevin	MAFPRN	Roadmap Plenary
Peterson	Kevin	MAFPRN	Poster
Prunuske	Jacob	Utah Health Research Network	IVB - Colorectal Cancer
Rothemich	Stephen	ACORN	IVC - Chronic Care Model
Rust	George	Southeast Regional Clinicians' Network	Health Disparities Plenary
Ryan	Alexandra		Poster
Sarter	Barbara	LANet	IC - Nutrition & Obesity
Singh	Gurdev	UNYNET	ID - Medication Safety
Sloane	Philip	NC-FP-RN	IC - Nutrition & Obesity
Sokolnicki	Annette	GRIN	Poster
Sommers	Lucia	UCSF Collaborative Practice Network	IIIC - Engaging Clinicians



## 2006 AHRQ PBRN Research Conference Participant List

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May 15-17, 2006

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Wallace	James	ORPRN	ID - Medication Safety
Wasson	John	The Dartmouth-Northern New England COOP Project	PBRN Pioneers Plenary
Wasson	John	The Dartmouth-Northern New England COOP Project	IID - Technology & Practice Change Workshop
Westfall	John	High Plains Research Network	IIIB - Community Participation Workshop
Williams	Robert	RIOS Net	Roadmap Plenary
Zafar	Atif	PBRN Resource Center	Monday HIT Workshop
Zittleman	Linda	High Plains Research Network	IIC - Rural PBRNs

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**General Information** [top](#)

The PBRN registration desk is located on the lobby level outside the Congressional Ballroom. Registration/Information Desk hours are as follows:

MONDAY, May 15	12:00 pm – 5:00 pm
TUESDAY, May 16	7:00 am – 5:30 pm
WEDNESDAY, May 17	7:30 am – 3:00 pm

**SPEAKER READY ROOM**

The speaker ready room is located in the Chesapeake Room which is on the lobby level. Speakers should report to the speaker ready room at least two hours in advance of their session to ensure adequate time for loading presentations onto the specific meeting room laptop computers.

Hours for the speaker ready room are the same as for registration/information as listed above.

**SESSIONS**

General sessions will be held in the Congressional Ballroom. Breakout sessions will be held in the three (3) separate sections of the Congressional Ballroom (Congressional Salon



## **2006 AHRQ PBRN Research Conference: General Information**

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*May 15-17, 2006*

1, Congressional Salon 2, and Congressional Salon 3) and the Pooks Hill/Kensington Room. All meeting space is located on the Lobby Level of the Bethesda Marriott.

### **POSTER BOARD SESSIONS AND POSTER RECEPTION**

Poster board sessions and the poster reception on Monday evening will be held in the Maryland Suite.

### **MEALS**

Luncheons on Tuesday and Wednesday will be served in the Grand Ballroom. There is a charge for the Luncheon Meal Package. Please inquire at the conference registration desk if you desire to purchase the Meal Package once you are on-site.

Continental breakfast, morning and afternoon breaks, and the poster reception are open to everyone, and we urge you to attend. There is no charge associated with these specific food and beverage functions.

***Personal Workplan: Monday***

[top](#)

**Workshop Session I:**

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**Workshop Session II:**

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**Workshop Session III:**

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## ***Personal Workplan: Tuesday:***

### **Opening Remarks:**

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### **PBRN Resource Center Update:**

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### **PBRNs at the Interface of Research and Quality:**

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### **Concurrent Session I**

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### **Networking Lunch:**

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### **PBRNs and Health Disparities Research::**

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### **Concurrent Session II:::**

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### **Concurrent Session III:**

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### **Additional Notes:**

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## 2006 AHRQ PBRN Research Conference: Presenter Disclosures

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May 15-17, 2006

### Presenter Disclosures [top](#)

The following speakers, session facilitators, and workshop moderators disclosed no actual or potential conflict of interest in regard to this program:

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John T. Lynch has disclosed that he is a paid employee of Pro Health Physicians, INC.

